Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **California** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Home and Community Based Alternatives Waiver

C. Waiver Number:CA.0139
Original Base Waiver Number: CA.0139.

D. Amendment Number:CA.0139.R06.01

E. Proposed Effective Date: (mm/dd/yy)

11/12/23

Approved Effective Date: 11/12/23
Approved Effective Date of Waiver being Amended: 01/01/23

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to include telehealth as a permanent service delivery option for specified waiver services, in compliance with California Welfare and Institutions Code section 14132.725; federal statute and regulations; and as agreed upon by the applicant, participant, legal representative, and Medi-Cal provider. Additionally, minor edits have been made to three performance measures for operational purposes and/or accuracy. The changes to the performance measure do not change the original intent or standards of the measures.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Additional Needed Information (Optional)

Component of the Approved Waiver	Subsection(s)
☒ Appendix A Waiver Administration and Operation	a-i
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	a-i-a
☒ Appendix D Participant Centered Service Planning and Delivery	a-i-e
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Adding authority to provide telehealth as a service delivery model for specified waiver services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Based Alternatives Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CA.0139
Waiver Number:CA.0139.R06.01
Draft ID: CA.016.06.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/23
Approved Effective Date of Waiver being Amended: 01/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Individuals must meet the criteria for hospital level of care (LOC) and the medical care criteria as described in Appendix B-1.

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

NF-A, NF-B, and NF-Subacute LOC

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Subcategory: ICF/DD-Continuous Nursing (CN) non-ventilator dependent and ICF/DD-CN ventilator dependent LOC.

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

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

The purpose of the HCBA Waiver, hereafter referred to as the "Waiver", is to provide Medi-Cal-eligible individuals who have long-term medical conditions and meet one of the designated LOC in subsection F, above, the option of returning to and/or remaining in a home or home-like community setting in lieu of institutionalization.

The goals of the Waiver are to: 1) facilitate a safe and timely transition of Medi-Cal eligible individuals from a medical facility or institutional setting to a home or community setting utilizing Waiver services; 2) offer eligible individuals who reside in the community but who are at risk of being institutionalized within the next 30 days, the option of utilizing Waiver services to develop a care plan that will safely meet their medical care needs outside of an institution; and 3) maintain overall cost neutrality of HCBS when compared to services that would be provided to the same population in an institution. The HCBA Waiver is the payer of last resort except where otherwise specified by law. A Waiver service of medical necessity may only be authorized as a Waiver service when it is not available to the participant through any other source, including but not limited to private insurance.

California’s Department of Health Care Services (DHCS) is the State’s Single Medicaid Agency responsible for statewide administration and monitoring of the Waiver. Organizationally, DHCS’ Integrated Systems of Care Division (ISCD) administers the Waiver. DHCS is responsible for reviewing and approving initial Waiver eligibility, LOC determinations, and ongoing monitoring and oversight of Waiver Agencies and HCBA Waiver service providers. DHCS maintains sole administrative responsibility for managing Waiver expenditures against approved levels; establishing rates; and the development of policies and procedures governing the Waiver program.

DHCS’ primary model for the administration and operation of the Waiver is through contracted Waiver Agencies responsible for local Waiver administration functions and for the delivery of the Comprehensive Care Management Waiver service provided by a CMT. Waiver Agency administration functions include: evaluating applicants’ eligibility for the Waiver; submitting enrollment applications and supporting documentation to DHCS for approval; conducting annual LOC evaluations; reviewing and approving participants' person-centered POTs; authorizing Waiver services; managing service utilization; developing and maintaining an HCBS provider network; engaging in quality assurance activities; and billing the DHCS fiscal intermediary (FI) when authorized by DHCS to provide direct care services (defined in “Additional Needed Information” of the Waiver).

Waiver Agencies provide Comprehensive Care Management through a CMT comprised of a Registered Nurse (RN) and a Social Worker with at least a Bachelor’s degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, and psychology, when supervised by a Social Worker with at least a Master’s degree (MSW). Both members of the CMT must be directly employed or contracted by the Waiver Agency. The CMT works with the participant to identify and coordinate State Plan and Waiver services, and other available resources that are necessary to enable the participant to transition to the community or remain in their own home. Only Waiver Agencies are authorized to receive payment for Comprehensive Care Management services within their contracted service areas. All other Waiver services are authorized by the Waiver Agency and delivered by willing and qualified Medi-Cal HCBS providers. In areas of the state where there are no willing and qualified HCBS providers, the Waiver Agency may provide Waiver services when pre-authorized to do so by the State, and after they have demonstrated compliance with 42 CFR 441.301(c)(1)(vi), including: 1) the Waiver Agency and/or an affiliate is the only willing and qualified provider to provide direct Waiver services within the service area; 2) the Waiver Agency developed and implemented thorough conflict of interest provisions to separate service plan development from the direct provision of Waiver services within their organization; 3) participants are provided with a clear and accessible alternative dispute resolution process to dispute the assertion that there is not another willing and qualified provider available to provide direct Waiver services included in the person-centered service plan; and 4) the CMT continues to search for willing and qualified HCBS providers to provide the direct care service(s) of medical necessity included in the participant’s care plan, document their recruitment efforts in the participant’s case notes, and attach the documentation to each direct care TAR submitted to DHCS for approval. Waiver Agencies may not authorize direct care TAR for their own staff or affiliated businesses.

Waiver Agencies provide Comprehensive Care Management Waiver services to assist Waiver participants develop a person-centered care plan; identify and secure the services of medical necessity from available Waiver providers; provide continuous case management of Waiver services; and coordinate with Medi-Cal MCPs and community-based programs to help participants have full access to the benefits of community living, and receive services in the most integrated setting of their choice.

In areas not covered by a Waiver Agency, DHCS is responsible for the Waiver administration functions. Under DHCS, case management is provided by willing and qualified HCBS providers enrolled in Medi-Cal to provide Waiver case management services. Waiver case management service providers receive the existing case management rate in the Medi-Cal fee schedule. All other Waiver services are provided by willing and qualified Medi-Cal providers approved to provide Waiver services, as outlined for each service in Appendix C.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

In reference to the proposed Telehealth Amendment language included under the Additional Needed Information (Optional) section of this waiver, on June 30, 2023 DHCS invited all interested entities to review amendment located on the HCBS website (https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx) and provide comment via a thirty (30) day public comment period. Invitations were sent via the Public Registrar, DHCS Stakeholder Communications and to Internal Stakeholder groups. Interested parties were invited to submit comments to the HCBA inbox, HCBAlternatives@dhcs.ca.gov. In addition to the public being able to submit comments electronically through the HCBA inbox, the public was able to submit comments through US mail to the address listed below:

Department of Health Care Services
Integrated Systems of Care Division
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7414

The public comment period ended on July 30, 2023.

Tribal notice was not necessary for this amendment, as per an email correspondence sent to Stephanie Hockman, Coordinator, DHCS Indian Health Program, on June 26, 2023, from Cynthia Lemesh, CMS Native American Contact, approving DHCS' request for No Tribal Notice.

DHCS received a total of 30 Comments from 15 entities regarding the telehealth. The comments did not include any HCBA Waiver specific feedback. Major themes received in support are summarized below:

•Maintaining health and wellness for persons who utilize these services.

•Allows Waiver agency employees to before efficient.
oTelehealth allows the Waiver Agency to operate remotely requiring less office space and less employees traveling, increasing productivity, and decreasing overhead.
oProviding telehealth visits has improved employee retention and decreased burnout.
oProviding telehealth visits have allowed Waiver Agency employees to maintain flexible schedules that are more accommodating to client's schedules.
oTelehealth visits allow Waiver Agency employees to be more efficient with the turnaround of documentation as compared to being out in the field.
oTelehealth visits allow for WA employees to reach out quickly in urgent situations to help find solutions for clients.

•Safety concerns reduced in travel.
oTelehealth visits allow for employees to avoid traveling in unsafe conditions such as flooding, wildfires, extreme heat and earthquakes.

•Appointment scheduling convenience
oA participant's family member may find it more convenient to join the telehealth visit via their cell phone/phone.
oTelehealth appointments are easier to schedule and provide many more time options for participants at their convenience.

DHCS did not make changes to the telehealth amendment in response to public comments.

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

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

7. Contact Person(s)

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

Last Name: Maslyn

First Name: Cortney

Title: Integrated Systems of Care, Division Chief

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue

Address 2: PO Box 997413, MS 4502

City: Sacramento

State: **California**

Zip: 95899-7413

Phone: (916) 713-8345 **Ext:** ☐ **TTY**

Fax: (916) 552-9660

E-mail: Cortney.Maslyn@dhcs.ca.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **California**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: MICHELLE BAASS

State Medicaid Director or Designee

Submission Date: Oct 31, 2023

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Baass

First Name: Michelle

Title: Director & Interim State Medicaid Director

Agency: Department of Health Care Services

Address: 1501 Capitol Ave.

Address 2: MS 0000

City: Sacramento

State: **California**

Zip: 95899-7413

Phone:

(916) 440-7400 **Ext:** ☐ **TTY**

Fax:

(916) 440-7404

E-mail:

Michelle.baass@dhcs.ca.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures that this Waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved HCBS Statewide Transition Plan. The State will implement any required changes by the end of the transition period as outlined in the HCBS Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

For the purposes of this Waiver, “direct care” is the provision of services that involves hands-on care provided to a Waiver participant. Including but not limited to hands-on services of medical necessity, regardless of funding source, such as:
• IHSS personal care services, including paramedical services, medical appointment accompaniment, and HCBA Waiver Personal Care Services
• HCBA Waiver paramedical services
• CBAS, or Adult Day Health Care (ADHC) services
• PDN and shared PDN
• Continuous Nursing and Supportive Service
• Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services
• CC/CNC, Ventilator Dependent Services
• Habilitation services
• Home or Facility respite
• Therapies that require hands-on interaction with the member (e.g., PT, OT, Speech Therapy (ST), Applied Behavioral Analysis (ABA))

Direct care services can be provided by a parent, spouse, personal caregiver, licensed healthcare provider, therapist, para-professional, educational or home health aide, etc.

Indirect care services do not require hands-on interaction between the care provider and the participant. Examples include, but are not limited to:
• Comprehensive Care Management
• Case Management
• Consultation between care providers
• IHSS that does not involve hands-on care, such as meal prep and clean up, shopping/errands, laundry, domestic care, yard hazard abatement, heavy cleaning, etc.
• Community Transition Services
• Environmental Accessibility Adaptations
• Family/Caregiver Training
• Medical Equipment Operating Expense
• Personal Emergency Response (PERS) Installation and Testing
• PERS Monthly Service
• Professional services that do not include the provision of hands-on personal or custodial care

Whether or not specific professional services qualify as direct or indirect services is within the discretion of the Department.

Waiver services, as identified in item #10 below, can be provided pursuant to California’s Medi-Cal’s Telehealth Policy, in alignment with California Welfare and Institutions Code section 14132.725, and as agreed upon by the applicant, beneficiary, legal representative, and provider. All authorized waiver service providers rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws. Telehealth delivery services must meet HIPAA requirements, and the methodology must be accepted by the state’s HIPAA compliance officer.

Waiver services provided via telehealth must also comply with all of the following requirements:

1. Participants must be allowed to choose to receive services, as identified in item #10 below, via telehealth or in-person.

2. Services provided via telehealth must meet the individual’s needs, as included in their person-centered care plan.

3. The waiver service provider believes that the service being provided via telehealth is clinically appropriate based upon evidence-based medicine or best practices or both. Additionally, the telehealth service must meet the procedural definition of the Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) code associated with the service, as well as follow any additional guidance provided by DHCS (e.g., through the DHCS Provider Manual).

4. Services will only be provided via telehealth if the needs of the beneficiary can be met remotely. Telehealth must not replace direct care that can only be provided in-person. If waiver participants’ needs cannot be met via telehealth, in-person assistance is required to support the waiver participants’ health and safety.

5. Services provided via telehealth must be delivered in a way that respects the privacy of the individual, especially in the instances of toileting, dressing, etc.

6. Providing the service via telehealth must not prevent the facilitation of community integration as defined in 42 CFR 441.301(c)(4). Remotely delivered services can be provided to multiple individuals at one time (without sharing private health information), which presents individuals the opportunity to interact with others, while receiving services in their preferred delivery method.

7. The waiver service provider must inform the patient prior to the initial delivery of telehealth services about the use of telehealth and obtain consent from the individual for the of telehealth as an acceptable mode of delivering health care services. If personal care is needed while telehealth was being provided, the individual and/or person supporting the individual would conduct personal care activities out of the line of sight of the telehealth provider, turn off video/audio communication during that time, or reschedule the telehealth visit. If the telehealth includes video cameras and/or monitoring devises, privacy must be protected. In instances where privacy cannot be secured by the individual, the telehealth provider would pause the telehealth service until confirming it was appropriate to resume.

8. Providing the service via telehealth must not impede, replace, or prevent the successful delivery of HCBS for individuals who need hands-on assistance/physical assistance.

9. Support must be provided to individuals who need assistance with using the technology required for the delivery of the HCBS via telehealth. The individual's person-centered planning team is responsible for determining the extent of training necessary for the individual to access their services remotely, and for ensuring that the necessary training is provided and understood by the individual or legal guardian. Family members may also be eligible for training, as appropriate, to support the provision of services if determined to be beneficial for the individual. If the individual is unable to properly utilize the technology, with or without assistance, then telehealth is not appropriate.

10. The following services can be provided via Telehealth, in alignment with the above requirements:
•Case Management
•Waiver Personal Care Services - Adult Companionship
•Community Transition Service
•Comprehensive Care Management
•Family/Caregiver Training
•Transitional Case Management

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Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

◉ **The Medical Assistance Unit.**

Specify the unit name:

Integrated Systems of Care Division

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

DHCS may, at its discretion, contract with local non-state public agencies to perform waiver operational and administrative activities/functions at the local level, as HCBA Waiver Agencies. These entities must meet DHCS' performance standards and requirements, including demonstrated organizational, administrative, and financial capabilities to carry out the contractual responsibilities/obligations of the HCBA Waiver.

DHCS contracts with Waiver Agencies to administer the Waiver program locally. These local Waiver Agencies represent a wide variety of service delivery agencies and geographic areas with diverse Waiver participant populations. DHCS reserves the right to limit the number of Waiver Agencies in a geographical area, at any time, for any reason. Waiver Agencies arrange for participants to receive Waiver Services through local Medi-Cal HCBS providers, submit complete enrollment packets to DHCS to enroll participants in the Waiver, perform initial and annual LOC evaluations, review person-centered participant care plans, authorize waiver services prior to utilization, develop networks of qualified providers, confirm that all HCBA Waiver providers are enrolled as Medi-Cal providers pursuant to state and federal law, obtain HCBA Waiver provider agreements from all HCBS providers before they provide services to a Waiver participant, perform quality assurance and reporting for submission to DHCS, submit claims to the DHCS FI when authorized by DHCS to provide direct care services, and adjudicate provider TARs. Waiver Agencies receive a flat rate payment per member each month, for performing these operational and administrative functions on behalf of DHCS. DHCS will make this administrative payment in a manner consistent with the State Allocation Plan, to the extent applicable.

All Waiver Agencies must comply with state and federal statue and Regulations, the HCBA Waiver Agency Agreement, and DHCS issued HCBA Waiver Policy Letters.

In areas where there is no Waiver Agency, DHCS performs all administrative functions outlined above. DHCS also maintains sole administrative responsibility for ensuring waiver expenditures do not exceed the approved levels, establishing rates for Waiver services, and instituting rules and policies governing the Waiver.

Waiver Agencies are responsible for adjudicating TAR submitted by willing and qualified Medi-Cal HCBS providers, for the following Waiver services:
• Habilitation Services
• Home Respite
• Waiver Personal Care Services
• Community Transitions Services
• Continuous Nursing and Supportive Services
• Developmentally Disabled/Continuous Nursing Care, Non-Ventilator Dependent Services
• Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services
• Facility Respite
• Family/Caregiver Training
• Medical Equipment Operating Expense
• Personal Emergency Response Installation and Testing
• Personal Emergency Response System
• Private Duty Nursing
• Assistive Technology
• Paramedical Services

☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

DHCS may, at its discretion, contract with local non-governmental non-state agencies to perform waiver operational and administrative activities/functions at the local level, as HCBA Waiver Agencies. These entities must meet DHCS' performance standards and requirements, including demonstrated organizational, administrative and financial capabilities to carry out the contractual responsibilities/obligations of the HCBA Waiver.

DHCS contracts with Waiver Agencies to administer the Waiver program locally. These local Waiver Agencies represent a wide variety of service delivery agencies and geographic areas with diverse Waiver participant populations. DHCS reserves the right to limit the number of Waiver Agencies in a geographical area, at any time, for any reason. Waiver Agencies arrange for participants to receive Waiver Services through local Medi-Cal HCBS providers, submit complete enrollment packets to DHCS to enroll participants in the Waiver, perform initial and annual LOC evaluations, review person-centered participant care plans, authorize waiver services prior to utilization, develop networks of qualified providers, confirm that all HCBA Waiver providers are enrolled as Medi-Cal providers pursuant to state and federal law, obtain HCBA Waiver provider agreements from all HCBS providers before they provide services to a Waiver participant, preform quality assurance and reporting for submission to DCHS, submit claims to the DHCS FI when authorized by DHCS to provide direct care services, and adjudicate provider TAR. Waiver Agencies will receive a flat rate payment per member each month, for performing these operational and administrative functions on behalf of DHCS. DHCS will make this administrative payment in a manner consistent with the State Allocation Plan, to the extent applicable.
All Waiver Agencies must comply with state and federal statue and Regulations, the HCBA Waiver Agency Agreement, and DHCS issued HCBA Waiver Policy Letters.

In areas where there is no Waiver Agency, DHCS performs all administrative functions outlined above. DHCS also maintains sole administrative responsibility for ensuring waiver expenditures do not exceed the approved levels, establishing rates for Waiver services, and instituting rules and policies governing the Waiver.

Waiver Agencies are responsible for adjudicating TAR submitted by willing and qualified Medi-Cal HCBS providers, for the following Waiver services:
• Habilitation Services
• Home Respite
• Waiver Personal Care Services
• Community Transitions Services
• Continuous Nursing and Supportive Services
• Developmentally Disabled/Continuous Nursing Care, Non-Ventilator Dependent Services
• Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services
• Facility Respite
• Family/Caregiver Training
• Medical Equipment Operating Expense
• Personal Emergency Response Installation and Testing
• Personal Emergency Response System
• Private Duty Nursing
• Assistive Technology
• Paramedical Services

Appendix A: Waiver Administration and Operation

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

State Medicaid Agency

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional

non-state entities is assessed:

DHCS shall monitor Waiver Agencies' performance at least every 12 months through onsite and/or electronic Quality Assurance Reviews (QAR) to assess the assigned Waiver operational and administrative functions (identified in item A-7) are performed in accordance with Waiver requirements. DHCS' monitoring and oversight of contracted Waiver Agencies' operational and administrative performance shall include, but not be limited to, the review of Waiver participant records, progress notes, LOC determinations, assessments, re-assessments, screening documents, timeliness of action, Waiver participant care plans, documentation of the audit trail, verification of service delivery, Waiver participants' satisfaction with the Waiver, and any other pertinent documentation. Waiver Agencies shall, upon the request of DHCS, provide to DHCS any requested data or information related to the Waiver Agency's services under the Waiver or the Waiver participants. These requests may require Waiver Agencies to provide the requested data or information at any time of the day or day of the week, including but not limited to, weekends, and during emergencies.

Noncompliance with Waiver and program standards may result in a plan of correction, technical assistance, and financial and/or enrollment sanctions. When corrective action is required, the Waiver Agencies must respond with a formal CAP to address any deficiencies. Upon initial approval of the CAP, DHCS monitors the Waiver Agencies' resolution process and may, at its discretion, conduct an on-site follow-up visit at the Waiver Agency to evaluate the effectiveness of the new practice(s), and/or request submission of records for additional review by DHCS. The Waiver Agency does not receive a CAP approval letter until complete resolution has been verified by DHCS.

DHCS may impose financial and/or administrative sanctions on Waiver Agencies that violate the terms of this Waiver, applicable State and federal laws and regulations, or the terms of the Waiver Agency contract with DHCS, including the requirement to comply with Policy Letters. Monetary sanctions may be imposed to address instances where repeated or unremediated deficiencies exist, or when noncompliance may affect the health and welfare of participants or applicants. In imposing monetary sanctions, DHCS may withhold a percentage of PMPM payments from Waiver Agencies until remediation is complete, or impose penalties in an amount commensurate with the impact of the violation(s) at issue. Administrative sanctions may include suspension of new enrollment activities and/or contract termination. Waiver Agencies will be provided with notice of intention to impose sanctions and an opportunity to appeal under the terms of the Waiver Agency contract. DHCS reserves the right to impose additional sanctions as appropriate.

DHCS provides ongoing technical assistance to Waiver Agencies and requires quarterly reports from each Waiver Agency that includes updates on enrollment levels, fiscal performance, and quality assurance activities. DHCS communicates regularly via telephone, email, and periodic meetings with Waiver Agencies.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒

Function	Medicaid Agency	Local Non-State Entity
Qualified provider enrollment	☒	☐
Execution of Medicaid provider agreements	☒	☒
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

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:
Number (#) and percent (%) of HCBA Waiver Agency Quarterly Performance Reports (QPRs) that are complete, and submitted to DHCS every quarter of the Waiver Year. Numerator: Total number of HCBA Waiver Agency QPR that are complete, and submitted to DHCS every quarter of the Waiver Year. Denominator: Total number of QPR that should be completed and submitted to DHCS every quarter of the Waiver Year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly Performance Reports

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 =
☒ **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: HCBA Waiver Agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
 # and % of annual HCBA Waiver Agency onsite and/or electronic QAR conducted by DHCS to determine if assigned Waiver functions are performed in accordance with Waiver requirements. Numerator: Number of annual QAR performed by DHCS / Denominator: Number of required case files reviewed for 372 report.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Assurance Review

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 =
☐ **Other** Specify:	☒ **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.

Oversight of waiver provider agencies and individual providers is included as an audit component during the annual QAR.

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.

When individual problems/discrepancies are discovered, DHCS will provide technical assistance or training, which may include, but is not limited to, clarifying waiver requirements, policies and procedures, or standards of participation. On a continuous and ongoing basis, DHCS may provide technical assistance, require CAPs, make revisions to policies and procedures when necessary, and conduct individual, case-by-case, follow-up, with the Waiver Agencies on specific issues to address and/or confirm the resolution of problems/discrepancies in a timely manner.

Using the strategies described above, DHCS will be able to collect and analyze data for trends and patterns of populations that are served, and document compliance with Waiver assurances.

DHCS can then develop remedial actions deemed necessary to provide the most optimal services to the HCBA Waiver population, while enforcing compliance with waiver assurances as well as DHCS policies and procedures.

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**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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		☒

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ 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 acute LOC services of medical necessity 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 acute LOC services of medical necessity 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 subacute LOC services of medical necessity 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 subacute LOC services of medical necessity 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 NF- A/B LOC services of medical necessity 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 NF-A/B LOC services of medical necessity 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 of medical necessity;
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, 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 services of medical necessity in the community setting of their choice.

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 with the Waiver Agency or DHCS to determine eligibility for enrollment. If a face-to-face 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, who are eligible in alignment with the following federal statute and regulations:
1902(a)(10)(A)(ii)(XXII); 1915(i); 1902(a)(10)(A)(ii)(I) and (IV); 2102(b)(1)(B)(v); 1902(a)(10)(C); 1902(a)(10)(A)(ii)(X), and 1902(m)(1); 1902(a)(10)(A)(i)(I); 1931(b) and (d); 408(a)(11)(A); 1902(a)(52); 1902(e)(1)(B); 1925; 1931(c)(2); 1902(a)(10)(A)(i)(I); 1902(a)(10)(A)(ii)(XVII); 1902(a)(10)(A)(i)(IX); 1902(a)(10)(A)(ii)(XIV); 1905(u)(2)(B); 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); 1931(b) and (d); 1902(a)(10)(A)(ii)(VIII); 408(a)(11)(B); 1931(c)(1); 1634(c); 1902(a)(10)(A)(ii)(XIII) 1619(b); 1902(a)(10)(A)(i)(II)(bb); 1905(q); 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); 1931(b) and (d); 1902(a)(10)(A)(ii)(XII); 1902(z); 1902(a)(10)(A)(i)(VIII); 1902(a)(10)(E)(ii); 1905(p)(3)(A)(i); 1905(s)
1902(a)(10)(E)(iii); 1905(p)(3)(A)(ii); 1902(a)(10)(E)(iv); 1905(p)(3)(A)(ii); 1902(a)(10)(A)(ii)(XXI); 1902(e)(4); 1902(a)(10)(C)(ii)(II); 1902(a)(10)(A)(i)(VIII); 1905z(3); 1902(a)(10) (A)(ii)(XXIII); 42 CFR 435.222; 42 CFR 457.310; 42 CFR 435.322; 42 CFR 435.110; 42 CFR 435.145; 42 CFR 435.226; 42 CFR 435.150; 42 CFR 435.229 and 435.4; 42 CFR 435.116; 42 CFR 435.320, 322 & 324; 42 CFR 435.227; 42 CFR 435.115; 42 CFR 435.324; 42 CFR 435.118; 42 CFR 435.215; 42 CFR 435.119; 42 CFR 435.214; 42 CFR 435.117; 42 CFR 435.320; 42 CFR 435.301(b)(1)(ii); 42 CFR 435.308; 42 CFR 435.310; 42 CFR 435.301(b)(1)(i) and (iv); 43 CFR 435.322 & 324

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:

- ( ) **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, and employed by the State Medicaid Agency will perform the initial LOC determinations for all HCBA Waiver applicants. LOC determinations may also be completed by a 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.

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 medical necessity acute LOC services, and choose to remain home, or to return home, to receive medical necessity 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.

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 of medical necessity;
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.

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 nurse assessment shows that the participant continues to meet LOC eligibility and that the home safety evaluation is complete.

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 nurse evaluation completed by the Waiver Agency. DHCS will review the initial, and periodic, nurse 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.

The Client Development Evaluation Report (CDER) contains diagnostic and evaluation information and is collected by all Regional Centers to determine the ICF/DD LOC of individuals. The CDER is divided into two major sections (or elements), the Diagnostic Element and the Evaluation Element. The Diagnostic Element contains information pertaining to the individual's developmental disability(ies), mental disorders, risk factors, major medical conditions, hearing and vision impairments, behavior modifying drugs, special health care requirements, and other special conditions. The Evaluation Element covers information relating to motor, independent living, social, emotional, cognitive, and communication skills.

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 applicant's LOC eligibility for enrollment into the HCBA Waiver, 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 of medical necessity. Medical necessity is defined as set forth in Welfare and Institutions Code §14059.5, as follows: A service is 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 conducting a nursing assessment of an individual, 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 with the potential waiver participant and a comprehensive evaluation is completed. HCS utilizes the information from the nursing assessment and face-to-face intake visit 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 medical necessity 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 medical necessity 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 medical necessity 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 medical necessity 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 medical necessity 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 medical necessity 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 nursing assessments or documentation, 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 LOC assessment completed by qualified personnel, RN, with a current license to practice in the State of California, prior to receipt of services. Numerator: # of LOC assessments completed by qualified personnel, RN, with a current license to practice in the State of California, prior to receipt of services/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 medical necessity 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.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Case Management**
Statutory Service	**Habilitation Services**
Statutory Service	**Home Respite**
Statutory Service	**Waiver Personal Care Services (WPCS)**
Extended State Plan Service	**Paramedical Service**
Other Service	**Assistive Technology**
Other Service	**Community Transition Services**
Other Service	**Comprehensive Care Management**
Other Service	**Continuous Nursing and Supportive Services**
Other Service	**Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services**
Other Service	**Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services**
Other Service	**Environmental Accessibility Adaptations**
Other Service	**Facility Respite**

Service Type	Service
Other Service	Family/Caregiver Training
Other Service	Medical Equipment Operating Expense
Other Service	Personal Emergency Response (PERS) Installation and Testing
Other Service	Personal Emergency Response Systems (PERS)
Other Service	Private Duty Nursing - Including Home Health Aide and Shared Services
Other Service	Transitional Case Management

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Case Management

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Case Management services are designed to assess the participant and determine their need for medical, psycho-social, social, and other services, and to assist them in gaining access to those medical necessity services and supports, regardless of the funding source. The goal of providing Case Management services is to help sustain the participant's health and safety through the home and community-based program. HCBA Case Management providers also assist participants in acquiring personal care providers as described in the participant's plan of care.

HCBA Case Management providers work with the participant, legal representative/legally responsible adult, and/or circle of support, and primary care physician in identifying goals and developing a course of action to respond to the assessed needs of the individual. HCBA Case Management providers assist the participant with the development and/or updating of the participant's primary care physician-signed POT, using person-centered planning techniques to help the participant understanding the various services they are receiving or may receive, as well as the impact of the services received/requested, based on the source of funding. HCBA Case Management providers also oversee the implementation of the services described in the POT and evaluate the effectiveness of those services.

HCBA Case Management provider responsibilities include: conducting clinical assessment(s) of the beneficiary; providing person-centered care planning; and, assisting with locating, coordinating, and monitoring services for community-based participants on the Waiver. HCBA Case Management provider services do not include the direct delivery of any other service.

HCBA Waiver Case Management service will not duplicate case management services available under the State Plan.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

The participant may choose to receive Case Management either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Main. Optional Additional Needed Information.

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

Case Management services are authorized only where an HCBA Waiver Agency is not present.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Professional Corporation
Individual	HCBS Waiver Nurse Provider - RN
Agency	Non-Profit Agency
Agency	Home Health Agency (HHA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS Waiver services approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide HCBA Waiver services to Waiver participants under the terms of the HCBA Waiver:

1. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

2. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

3. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

4. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as a HCBS Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or, if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as HCBS Waiver providers must provide DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State’s Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration (California Corporations Code §13401(b)). The Professional Corporation must notify DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to DHCS upon enrollment and upon request. The Professional Corporation must notify DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render Waiver services to Waiver participants, as requested and authorized, and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS. The Professional Corporation must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, at least, a minimum of 1,000 hours of experience in providing Case Management services to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate

documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

6. Provide HCBA Waiver services consistent with the participant's medical necessity services to safely live in a community-based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

a. Develop the POT consistent with the assessment of the Waiver participant and the participant's current primary care physician's orders for care. Collaborate with the waiver participant's current primary care physician in the development of the POT to address the waiver participant's medical care needs. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services, and the expected outcomes.

b. Facilitate the process of assessing the Waiver participant at the frequency described in the POT for progress and response to the care provided under the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT to reflect the medical needs of the waiver participant as determined by the participant's current primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the participant and/or legal representative/legally responsible adult, and the participant's current primary care physician no less frequently than once every six months.

c. Submit the initial POT to DHCS for approval of HCBA Waiver enrollment and services.

i. DHCS will review the initial and periodic POTs and supporting documents to determine that the requested waiver services are medical necessity and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant, and/or legal representative/legally responsible adult(s) participated in the development of the POT and was informed of their choice to freely select qualified providers.

ii. DHCS may request additional documentation supporting the medical necessity of the services described in the POT and discuss any necessary or suggested revisions of the POT with the provider. Modifications to the POT can only be made with the approval of the participant's current primary care physician and the participant and/or their legal representative/legally responsible adult(s). DHCS will not complete enrollment of the participant in the HCBA Waiver, nor authorize requested waiver services, until the POT accurately reflects the participant's need for services to safely live in a community-based setting, the providers of those services, any goals for the participant, and identifies and describes the plan to correct any safety issues.

f. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§ 2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

1.Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means Case Management as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in the home or community-based residence by an HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To help protect the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action, or is currently pending or being investigated for, but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

DHCS staff shall verify that any provider of waiver services continues to meet the waiver program requirements at the point of provider enrollment and thereafter as necessary, through credentialing desk review and onsite provider visits.

Qualifications of the HCBS Waiver RN
In addition to completing the Medi-Cal provider application and enrolling as a Medi-Cal provider, the HCBS Waiver RN shall provide all of the following documentation, in a format acceptable by DHCS:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for

individuals at one or more of the levels of care specified in this waiver.

The HCBS Waiver RN providing Case Management services shall:

1. Prepare a detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders. The appropriateness of the nursing assessment and interventions shall be determined by DHCS based upon the waiver participant's medical condition and medical necessity care need(s) to safely live at home or in a community-based setting. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.

2. Obtain a signed release form from the waiver participant's current primary care physician, which shall specify both of the following:

a. The participant's current primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

b. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

3. Prepare a written home safety evaluation, in a format acceptable to DHCS that demonstrates that the waiver participant's home environment is adequate to supports the health and safety of the individual. This documentation shall include all of the following:

a. A determination that the area where the waiver participant will receive care will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required. The home safety evaluation shall include a diagram of the participant's home.

b. Primary and backup utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

c. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

d. All medical equipment, supplies, primary and backup systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant begins receiving services.

3. Obtain medical information that supports the request for the services. This information may include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21, and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.

4. Submit the following documentation to DHCS, annually:

a. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.

b. Written evidence, in a format acceptable to DHCS, of on-going education or training caring for the waiver participants for whom services are being provided, at least once per calendar year.

c. Written summary of the Case Management activities provided.

d. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the physician of the participant's progress and updating and renewing the participant's current primary care physician orders.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Case Management Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Has filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintains General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based Case Management services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Case Management services and, at least annually, reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render Case Management services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing Case Management services to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of all requirements of the waiver SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS within 30 days of the change of

licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

10. Employs qualified professional providers to provide HCBA Waiver Case Management services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals for inspection and review by DHCS.

11. The Non-Profit Organization must provide Case Management services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience as follows:

A. Develop the POT consistent with the assessment of the waiver participant and the current primary care physician's orders for care. Collaborate with the waiver participant's current primary care physician in the development of the POT to address the waiver participant's medical care needs. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services and the expected outcomes.

B. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT as directed by the participant's current primary care physician to reflect the medical needs of the waiver participant, as determined by the participant's current primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the participant and/or legal representative/legally responsible adult, and the participant's current primary care physician, no less frequently than, once every six months.

C. Submit the POT to DHCS for approval of HCBA Waiver enrollment and services.

a. The POT and supporting documents will be reviewed by DHCS to determine that the requested waiver services are medical necessity and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant, legal representative/legally responsible adult(s), and/or circle of support participated in the development of the POT and was informed of their free choice to select qualified providers.

b. DHCS may request additional documentation supporting the medical necessity of the services described in the POT, and the Case Management Provider will discuss any necessary or suggested revisions of the POT with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant, and/or legal representative/legally responsible adult(s). DHCS will not complete the enrollment of the applicant in the HCBA Waiver or authorize requested waiver services, until the POT is revised by the Case Manager to accurately reflect the participant's needs, services, providers, goals, and/or correction of any safety issues.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the POT signed by the participant's current primary care physician. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Home Health Agency (HHA)

Provider Qualifications

License *(specify):*

Health and Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Habilitation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

As defined in §1915(c)(4)(B) of the SSA, habilitation 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.

Habilitation services include prevocational, educational, and supported employment services; but do not include:
• Special education and related services that are available to the individual through a local educational agency; nor
• Vocational rehabilitation services that are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Habilitation services are provided in a participant's natural environment, including their home or an out-of-home, non-facility setting. Some habilitation services can be provided by an unlicensed caregiver with the necessary training and supervision, including qualified peer mentors.

Habilitation services include training on:
• The use of public transportation;
• Personal skills development in conflict resolution;
• Community participation;
• Developing and maintaining interpersonal relationships;
• Personal habits;
• Daily living skills (cooking, cleaning, shopping, money management); and,
• Community resource awareness such as police, fire, or local services to support independence in the community.

It also includes assistance with:
• Locating, using and caring for canine and other animal companions specifically trained to provide assistance;
• Selecting and moving into a home;
• Locating and choosing suitable housemates;
• Locating household furnishings;
• Settling disputes with landlords;
• Managing personal financial affairs;
• Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
• Dealing with and responding appropriately to governmental agencies and personnel;
• Asserting civil and statutory rights through self-advocacy; and
• Building and maintaining interpersonal relationships, including a circle of support.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

The services under the HCBA Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. The HCBA Waiver is the payer of last resort, and medical necessity Habilitation services may only be authorized as a Waiver service for participants under the age of 21 when it is not available to them through any other system, including but not limited to: 1915(i) state plan coverage, private insurance, etc.

When a participant does not have a CMT, the HCBS individual provider may provide Habilitation services following approval from the DHCS MC.

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

Neither the Waiver Agency nor DHCS will authorize direct care services, or any combination of direct care and protective supervision services, exceeding 24 hours of care per day under this waiver, regardless of the funding source. Direct care services are defined in the "Additional Needed Information" section of this Waiver. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Professional Corporation
Agency	Non-Profit Agency
Agency	HHA
Individual	HCBS Waiver Nurse Provider - RN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide HCBS to Waiver participants under the terms of the HCBA Waiver:

1. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

2. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

3. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

4. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as a HCBA Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or, if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as an HCBA Waiver provider must provide the Waiver Agency or DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State's Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration (California Corporations Code §13401(b)). The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to the Waiver Agency or DHCS upon enrollment and upon request. The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render HCBA Waiver services to Waiver participants, as requested and authorized, and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by the Waiver Agency or DHCS. The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum

of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by the Waiver Agency or DHCS.

6. A Professional Corporation must provide HCBS consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years or as long as the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor

the license status of its licensed employees and report any changes to DHCS within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Habilitation services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health and Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in the home or place of residence by and HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. A HCBS Waiver RN must provide Habilitation services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. A HCBS Waiver RN must provide Habilitation services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Home Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The Home Respite benefit is intermittent medical and/or non-medical care supervision provided to the participant in their home or community-based setting to do the following:

1. Assist family members in maintaining the participant at home;
2. Provide appropriate care and supervision to protect the participant's safety in the absence of family members or caregivers;
3. Relieve family members from the constantly demanding responsibility of caring for a participant; and
4. Attend to the participant's medical and non-medical needs and other ADLs, which would ordinarily be performed by the family member.

The Home Respite benefit, as authorized, is to temporarily replace non-medical care that was provided to the participant by their legal representative/legally responsible adult(s) for a scheduled period of time as previously authorized or approved by the Waiver Agency or DHCS MC. When a participant does not have a Waiver Agency, an HCBS individual provider may provide Home Respite services following approval from the DHCS MC.

Waiver participants whose complex medical care needs meet the acute hospital facility LOC, requiring frequent evaluation by a licensed provider(s) who is skilled in and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's current primary care physician are not eligible to receive Home Respite services provided by an unlicensed provider. This requirement is consistent with the California Business and Professions Code, §2725 et seq.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

The services under the HCBA Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

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

Neither the Waiver Agency nor DHCS will authorize direct care services, or any combination of direct care and protective supervision services, exceeding 24 hours of care per day under this waiver, regardless of the funding source. Direct care services are defined in the "Additional Needed Information" section of this Waiver. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-Profit Agency
Individual	HCBS Waiver Nurse Provider - RN
Agency	Personal Care Agency
Individual	Waiver Personal Care Service (WPCS) Provider
Agency	Employment Agency

Provider Category	Provider Type Title
Agency	HHA
Individual	HCBS Waiver Nurse Provider - LVN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

1. Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:
The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS within 30 days of the

change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Home Respite waiver services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or community-based residence by an HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBA Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meets waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBA Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBA Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. A HCBS Waiver RN must provide Home Respite services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. A HCBS Waiver RN must provide Home Respite services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCs and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

California Business License

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBA Waiver Standards of Participation

A Personal Care Agency is a provider that employs individuals who provide services, is enrolled as an HCBA provider in the HCBA Waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency.

The minimal qualifications for the Personal Care Agency include:

1. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

2. Maintains a bond, or deposit in lieu of bond, in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code § 1812.500 through 1812.544) of the Civil Code, with the Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Personal Care Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBA Waiver provider.

If a Personal Care Agency claims exemption from the bond requirements of the Employment Agency, Employment Counseling, and Job Listing Services Act, the Personal Care Agency owner or officer shall provide a declaration under penalty of perjury that its operations or business do not require the filing of a bond pursuant to the Employment Agency, Employment Counseling, and Job Listing Services Act, and specifically identify the reason why no bond is required. The declaration must also contain the date, place of signature (city or county), and signature of the officer or owner.

3. Provide training and/or in-services to all its HCBA Waiver Home Respite providers and provide review training at least annually for a minimum of eight (8) hours. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:
• Companionship services
• Activities of daily living
• Basic first aid
• Bowel and bladder care
• Accessing community services
• Basic nutritional care
• Body mechanics

4. Employ individuals who will render Medi-Cal HCBA Waiver Home Respite services to participants as authorized by the Waiver Agency or DHCS and, who have work experience that includes a minimum of 1,000 hours of experience within the previous two years in providing companionship, assistance with ADLs, basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community. The Personal Care Agency must provide and maintain adequate documentation of the minimum hours of work experience for each of its employees for inspection and review by the Waiver Agency or DHCS.

5. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51183.

6. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code §12300, et seq., 14132.95, and 14132.97.

8. Comply with the terms and conditions provided in the waiver under which the services are provided.

9. A Personal Care Agency must provide Home Respite services consistent with the participant's choice

and interests, the participant's current primary care physician's orders and the HCBA Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDAA Community Care Licensing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Individual

Provider Type:

Waiver Personal Care Service (WPCS) Provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBA Waiver Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and or Waiver Agency

Frequency of Verification:

Upon request of services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:

Employment Agency

Provider Qualifications

License *(specify):*

California Business License

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBA Waiver Standards of Participation

An Employment Agency is a provider that employs individuals who provide Home Respite Services, is enrolled as an HCBA Waiver Employment Agency provider, and meets and maintains the Standards of Participation minimal qualifications for an Employment Agency.

The minimal qualifications for the Employment Agency will include:

1. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

2. Must maintain a bond, or deposit in lieu of bond, in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code §1812.500 through 1812.544) of the Civil Code ("the Act"), with the California Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Employment Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBA Waiver provider.

If an Employment Agency claims exemption from the bond requirements of "the Act", the Employment Agency owner or officer (as authorized by the Employment Agency) shall provide a declaration under penalty of perjury that its operations and/or business do not require the filing of a bond pursuant to the Act and specifically identify the exemption under the Act that applies to the Employment Agency. The declaration under penalty of perjury must also contain the date, place of signature (city or county), and signature of the officer or owner.

3. Provide a minimum of eight (8) hours of training and/or in-services to all its HCBA Waiver Home Respite providers, and review training and/or in-services at least annually. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:
• Companionship services
• Activities of daily living
• Basic first aid
• Bowel and bladder care
• Accessing community services
• Basic nutritional care
• Body mechanics

4. Employ individuals who will render HCBA Waiver Home Respite services to the participants as authorized by the Waiver Agency or DHCS and, who have a minimum of 1,000 hours of experience within the previous two years in providing companionship, assistance with ADLs, basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.

5. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51183.

6. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code §12300, et seq., 14132.95, and 14132.97.

8. Comply with the terms and conditions provided in the HCBA Waiver under which the services are provided.

9. An Employment Agency must provide Home Respite services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCBA Waiver POT

within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health and & Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - LVN

Provider Qualifications

License *(specify):*

BPC, Div. 2, Chptr 6.5
CCR, Title 16, Div. 25, Chptr 1CCR Title 22, §51069

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-LVN” means a Licensed Vocational Nurse who provides HCBS Waiver LVN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver LVN services” means private duty nursing services, as described in the HCBA Waiver in Appendix C (Participant Services), provided to a waiver participant in their home or community-based residence by an HCBA Waiver LVN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider-LVN application will not be processed should it be determined through official documentation that the LVN’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• LVNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet Waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of Waiver services continues to meet the Waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBA Waiver LVN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBA Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBA Waiver LVN acting as a direct care provider
The initial HCBA Waiver provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an LVN in the State of California. The LVN shall notify the Waiver Agency or DHCS in writing of any change in the status the LVN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

D. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience.

Annually the HCBA Waiver nurse provider shall submit the following documentation to the Waiver Agency or DHCS:

A. Evidence of renewal of BLS certification and unencumbered LVN licensure prior to expiration.

B. If services have been rendered within the last 12 calendar months, written evidence, in a format acceptable to the Waiver Agency or DHCS, of on-going education or training caring for the type of individual for whom services are being provided, at least once per calendar year.

C. If services have been rendered within the last 12 calendar months, a copy of the most recent POT that reflects the on-going CMT or HCB Case Management provider assessment and updated primary care physician orders. The POT shall be signed by the participant and/or legal representative/legally responsible adult, the waiver participant's current primary care physician, the supervising RN, and the LVN, and shall contain the dates of service.

D. Evaluation of PDN services provided.

E. If services have been rendered within the last 12 calendar months, written evidence of ongoing contact with the supervising RN, CMT or HCBA Case Management provider and waiver participant's current primary care physician.

F. If private duty nursing is regularly scheduled, the HCBA Waiver LVN must notify the Waiver Agency or DHCS and the waiver participant and/or legal representative/legally responsible adult(s), in writing, at least 30 days prior to the effective date of termination when the HCBA Waiver LVN intends to terminate HCBS, LVN services. This time period may be less than 30 days if there are immediate issues of health and safety for either the nurse or the waiver participant, as determined by the Waiver Agency or DHCS.

G. An LVN must provide Home Respite Nursing services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCBA Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Vocational Nursing and Psychiatric Technicians
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Waiver Personal Care Services (WPCS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

HCBA Waiver Standards of Participation

WPCS was established by legislation in 1998 through Assembly Bill (AB) 668 which added §14132.97 to the Welfare and Institutions Code. WPCS is designed to assist the waiver participant in gaining independence in their activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in their home residence and continuing to be part of the community. WPCS must be described in the participant's current primary care physician-signed POT, which must be signed by the participant, legal representative/legally responsible adult(s), the participant's current primary care physician, and each WPCS provider. A separate page for WPCS provider signatures may be attached to a POT provided by a Home Health Agency.

A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care program (In-Home Supportive Services (IHSS)) to receive WPCS through the HCBA Waiver. DHCS is mandated by state law to use CMIPS when paying an independent provider of WPCS. Additionally, IHSS and WPCS hours are counted together towards the Overtime Limits, as described in WIC section 12300.4. Individuals receiving WPCS through the HCBA Waiver must be enrolled in IHSS to use the Case Management Information and Payrolling System (CMIPS) and associated Electronic Timesheet System that is used to authorize WPCS timesheets, even if the individual does not receive IHSS.

Waiver participants whose complex medical care needs meet the acute hospital facility LOC, requiring frequent evaluation and/or intervention by a RN or LVN who is skilled and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's current primary care physician, are not eligible for this service. This requirement is compliant with the California Business and Professions Code, §2725.

The WPCS benefit includes:

• Assistance to Independence in their ADLs: Assisting the participant in reaching a self-care goal, the WPCS provider promotes the participant's ability in obtaining and reinforcing their highest level of independence in ADLs. The WPCS provider provides assistance and feedback to the participant in an effort to help them reach specific self-care goals in performing or directing caregivers in an activity without assistance from others. Services provided by the WPCS provider are verbal cueing, monitoring for safety, reinforcement of the participant's attempt to complete self-directed activities, advising the primary caregiver of any problems that have occurred; providing information for updating the participant's POT and addressing any self-care activities with an anticipated goal completion date.

• Adult Companionship: Adult companionship is for waiver participants who are isolated and/or may be homebound due to their medical condition. Adult companions must be at least 18 years of age and able to provide assistance to participants enrolled in the waiver. Waiver participants utilizing Adult Companionship must be at least 18 years old. Adult Companion services include non-medical care, supervision, and socialization provided to a waiver participant. To help maintain a waiver participant's psychological well- being, adult companions may assist waiver participants in accessing self-interest activities or accessing activities in the local community for socialization and recreational purposes, and/or providing or supporting an environment conducive to interpersonal interactions. Documentation of the need for adult companionship, the goal, process for obtaining the goal and progress in meeting the goal must be identified on the POT and submitted to the Waiver Agency or DHCS, for the initial and reauthorization/re-approval of services. The participant may choose to receive WPCS-Adult Companionship either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Main. Optional Additional Needed Information.

• The WPCS Benefit While Participant is Admitted to a Health Care Facility: WPCS providers may be paid while the participant is admitted to a health care facility (as defined in Health and Safety Code §1250) for services provided outside the health care facility setting for a maximum of seven (7) days for each admission to a health care facility (or for the length of the admission to the health care facility, whichever period is shorter). This payment is necessary to retain the WPCS provider for the continuation of services and facilitate the waiver participant's transition home or community-based residence. In order to receive WPCS benefits while admitted to a health care facility, the waiver participant must be enrolled and currently receiving State Plan Personal Care Services as authorized by Welfare and Institutions Code §14132.95 and receiving WPCS benefits within the prior month of the admission into the health care facility. Each time the participant is admitted to a health care facility, the WPCS provider must submit written documentation to the Waiver Agency or DHCS describing the specific activities performed, the amount of time each activity required, and the total hours they worked (e.g., 7:00 a.m. to 11:00a.m.

and 2:00 p.m. to 4:00 p.m.).

While the participant is admitted to a health care facility the WPCS provider can provide:
1. Routine housekeeping in the participant's absence;
2. Collection of mail and other deliverables in the participant's absence and contacting or visiting the participant to assist in responding to mail;
3. Food shopping for the participant's return to home;
4. Assistance in obtaining medications and medical supplies for the participant's return home; and
5. Availability to accept delivery of durable medical equipment and supplies at the participant's home.

WPCS providers will not be paid for care that duplicates the care that is required to be provided by the health care facility during the participant's admission. This type of care may include bathing, feeding, ambulation, or direct observation of the waiver participant.

Provider Requirements

WPCS providers under this waiver are the following:

1. An individual enrolled as a WPCS provider who is not otherwise employed by an employment agency, personal care agency, home health agency, IHSS Public Authority, or non-profit organization and is an individual who is employed directly by the Waiver participant receiving WPCS services under the waiver.

Individuals are permitted to enroll in the Medi-Cal program as a Personal Care Service provider pursuant to Welfare and Institutions Code §14132(t) and Title 22, CCR, §51246. WPCS providers must meet the same criteria and be enrolled as a provider of Personal Care Services through IHSS.

2. An Employment Agency, as defined in the HCBA Waiver SOP;

3. A Personal Care Agency, as defined in the HCBA Waiver SOP;

4. An HHA WPCS provider. Pursuant to the authority under Welfare and Institution Code §14132(t) and Title 22, CCR, §51246, a HHA providing WPCS services to a waiver participant shall meet the same definition of and criteria for participation as required in the Medi-Cal program. An HHA providing WPCS services shall be reimbursed for WPCS services as provided pursuant to the HCBA Waiver.

5. A Non-Profit Agency as defined by the HCBA Waiver SOP

To protect and sustain the health, safety and welfare of waiver participants, WPCS providers must be awake, alert and present during the scheduled hours of service and immediately available to the participant. Participants authorized for more than 360 hours a month of combined State Plan (such as IHSS services) and/or WPCS benefits, must receive that care from two or more State Plan (such as IHSS) and/or WPCS providers. A WPCS provider will not be paid to work more than 12 combined hours per day.

WPCS provider shall sign each Time Report and certify under penalty of perjury under the laws of the State of California, that the provisions of the services identified in the Time Report were provided by the WPCS provider and that the hours reported are correct.

In the event of an overpayment for any reason, the amount of the overpayment will be deducted from future warrants. If the individual is no longer a WPCS provider, the State reserves the right to pursue payment directly from the individual provider for the amount due.

In areas of the state where there is not a Waiver Agency and the WPCS provider is working with the participant to prepare the person-centered POT, the Non-Profit Organizations, Personal Care Agencies, Employment Agencies, Home Health Agencies, and Non-Profit Agencies providing WPCS must submit a POT to DHCS for prior authorization or approval of WPCS. The POT must be signed by the participant and/or legal representative/legally responsible adult, a representative of the agency submitting the POT and the waiver participant’s current primary care physician.

Prior to rending any WPCS services under the HCBA waiver, the provider must be enrolled as an IHSS provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a WPCS provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

Neither the Waiver Agency nor DHCS will authorize direct care services, or any combination of direct care and protective supervision services, exceeding 24 hours of care per day under this waiver, regardless of the funding source. Direct care services are defined in the "Additional Needed Information" section of this Waiver. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

Overtime:
On October 1, 2013, the United States Department of Labor published the Final Rule on applying the FLSA to domestic service providers which went into effect on February 1, 2016. FLSAs new overtime rule requires overtime (time and a half) pay for WPCS, paramedical service, and/or IHSS providers when they work more than 40 hours in a workweek. The workweek begins at 12 a.m. on Sunday, and ends at 11:59 p.m. the following Saturday. A single provider who works for a single participant can work up to 70-hours and 45-minutes of combined WPCS, paramedical services, and IHSS hours in one workweek. A single provider who works for multiple participants cannot work more than 66 hours in one workweek. WPCS hours will continue to be subject to a maximum work day of 12 combined hours. Each provider must establish a regular workweek schedule for each participant they serve, not to exceed the 70-hours and 45-minutes of WPCS, paramedical services, and IHSS hours combined, and not to exceed the participant's authorized weekly and monthly hours.

Travel Time:
Beginning February 1, 2016, WPCS providers who work for more than one participant may be eligible for travel time up to 7 hours per workweek. If an individual provider works over 40 hours in one workweek, travel time will be paid at time and a half. Travel time is the time it takes to travel directly from one participant to another on the same day to provide WPCS only or a combination of WPCS, paramedical services, and IHSS.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Agency
Agency	HHA
Agency	Personal Care Agency
Agency	Non-Profit Agency
Individual	WPCS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Agency

Provider Type:

Employment Agency

Provider Qualifications

License *(specify):*

California Business License

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBA Waiver Standards of Participation

An Employment Agency is a provider that employs individuals who provide Waiver Personal Care Services, is enrolled as an HCBA Waiver Employment Agency provider, and meets and maintains the Standards of Participation minimal qualifications for an Employment Agency.

The minimal qualifications for the Employment Agency will include:

1. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

2. Must maintain a bond, or deposit in lieu of bond, in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code §1812.500 through 1812.544) of the Civil Code ("the Act"), with the California Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Employment Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBA Waiver provider.

If an Employment Agency claims exemption from the bond requirements of "the Act", the Employment Agency owner or officer (as authorized by the Employment Agency) shall provide a declaration under penalty of perjury that its operations and/or business do not require the filing of a bond pursuant to the Act and specifically identify the exemption under the Act that applies to the Employment Agency. The declaration under penalty of perjury must also contain the date, place of signature (city or county), and signature of the officer or owner.

3. Provide training and/or in-services to all its HCBA Waiver Personal Care providers and review training at least annually for a minimum of eight (8) hours. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:
• Companionship services
• Activities of daily living
• Basic first aid
• Bowel and bladder care
• Accessing community services
• Basic nutritional care
• Body mechanics

4. Employ individuals who will render HCBA Waiver Personal Care services to the participants as authorized by the Waiver Agency or DHCS and, who have a minimum of 1,000 hours of experience within the previous two years in providing companionship, assistance with ADLs, basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.

5. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51183.

6. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code §12300, et seq., 14132.95, and 14132.97.

8. Comply with the terms and conditions provided in the HCBA Waiver under which the services are provided.

9. An Employment Agency must provide Waiver Personal Care services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCBA Waiver

POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

HHA CCR Title 22 §74659 et seq.

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

California Business License

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBA Waiver Standards of Participation

A Personal Care Agency is a provider that employs individuals who provide services, is enrolled as an HCBA provider in the HCBA Waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency.

The minimal qualifications for the Personal Care Agency include:

1. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

2. Maintains a bond, or deposit in lieu of bond, in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code §1812.500 through 1812.544) of the Civil Code, with the Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Personal Care Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBA Waiver provider.

If a Personal Care Agency claims exemption from the bond requirements of the Employment Agency, Employment Counseling, and Job Listing Services Act, the Personal Care Agency owner or officer shall provide a declaration under penalty of perjury that its operations or business do not require the filing of a bond pursuant to the Employment Agency, Employment Counseling, and Job Listing Services Act, and specifically identify the reason why no bond is required. The declaration must also contain the date, place of signature (city or county), and signature of the officer or owner.

3. Provide training and/or in-services to all its HCBA Waiver Personal Care providers and provide review training at least annually for a minimum of eight (8) hours. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:
• Companionship services
• Activities of daily living
• Basic first aid
• Bowel and bladder care
• Accessing community services
• Basic nutritional care
• Body mechanics
4. Employ individuals who will render Medi-Cal HCBA Waiver Personal Care services to participants as authorized by the Waiver Agency or DHCS and, who have work experience that includes a minimum of 1,000 hours of experience within the previous two years in providing companionship, assistance with ADLs, basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community. The Personal Care Agency must provide and maintain adequate documentation of the minimum hours of work experience for each of its employees for inspection and review by the Waiver Agency or DHCS.

5. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51183.

6. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, §51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code §12300, et seq., 14132.95, and 14132.97.

8. Comply with the terms and conditions provided in the waiver under which the services are provided.

9. A Personal Care Agency must provide Waiver Personal Care services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCBA Waiver

POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDSS Community Care Licensing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor

the license status of its licensed employees and report any changes to DHCS within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Waiver Personal Care services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Individual

Provider Type:

WPCS Provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBA Waiver Standards of Participation

Overtime:
On October 1, 2013, the United States Department of Labor published the Final Rule on applying the FLSA to domestic service providers which went into effect on February 1, 2016. FLSAs new overtime rule requires overtime (time and a half) pay for WPCS, paramedical service, and/or IHSS providers when they work more than 40 hours in a workweek. The workweek begins at 12 a.m. on Sunday, and ends at 11:59 p.m. the following Saturday. A single provider who works for a single participant can work up to 70-hours and 45-minutes of combined WPCS, paramedical services, and IHSS hours in one workweek. A single provider who works for multiple participants cannot work more than 66 hours in one workweek. WPCS hours will continue to be subject to a maximum work day of 12 combined hours. Each provider must establish a regular workweek schedule for each participant they serve, not to exceed the 70-hours and 45-minutes of WPCS, paramedical services, and IHSS hours combined, and not to exceed the participant's authorized weekly and monthly hours.

Travel Time:
Beginning February 1, 2016, WPCS providers who work for more than one participant may be eligible for travel time up to 7 hours per workweek. If an individual provider works over 40 hours in one workweek, travel time will be paid at time and a half. Travel time is the time it takes to travel directly from one participant to another on the same day to provide WPCS only or a combination of WPCS, paramedical services, and IHSS.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

At the time of service request and modification

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Paramedical Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Paramedical services are defined as "supportive services" in Welfare & Institutions Code §12300.1 as: "…services that are ordered by a licensed health care professional who is lawfully authorized to do so, which persons could provide for themselves but for their functional limitations. Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional. These necessary services shall be rendered by a provider under the direction of a licensed health care professional, subject to the informed consent of the recipient obtained as a part of the order for service."

Paramedical services are also governed by:
• Section 51350, Title 22, California Code of Regulations, as follows "(e) Paramedical services when included in the personal care plan of treatment must be ordered by a licensed health care professional lawfully authorized by the State. The order shall include a statement of informed consent saying that the beneficiary has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the beneficiary, the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. . . . . Catheter insertion, ostomy irrigation and bowel program are ... paramedical. ...(h)(1) ... if decubiti have developed, the need for skin and wound care is a paramedical service."

To be eligible to receive HCBA Waiver paramedical services, a waiver participant must be enrolled in and receiving paramedical services through the federally funded state plan personal care program (In-Home Supportive Services (IHSS)), and must have exhausted the approved IHSS hours prior to receiving paramedical services through the HCBA Waiver. The HCBA Waiver paramedical service will be provided by an enrolled IHSS provider trained to provide paramedical services to the recipient in alignment with IHSS program rules.

Paramedical services require pre-authorization, and the Waiver Agency or DHCS must receive the following documentation in order to authorize paramedical services:
• A signed and dated order for the paramedical services from the licensed health care professional (LHCP) who is lawfully authorized to issue such an order within their scope of practice. The order must include a statement of informed consent signed and dated by the participant, their legal representative, and/or legally responsible adult(s), documenting that the LHCP has informed them of the potential risks arising from receipt of paramedical services, and that they understand and accept the risk(s).
• The ordered paramedical services must be specifically described in the completed POT, and include the signature(s) of the paramedical service provider(s). A separate page for paramedical service provider signatures may be attached to a POT.

Paramedical services cannot be authorized prior to receipt of the LHCP's signed order for such services. However, the cost of medical necessity paramedical services that were received may be reimbursed retroactively if they are consistent with the subsequent authorization, were provided by an enrolled IHSS provider with an approved waiver to provide paramedical IHSS, and were received on or after the date of submission of the request for authorization of the paramedical services.

Providers will not be paid for paramedical services while a participant is admitted to a health care facility, as this type of care duplicates the care that the health care facility is required to provide during the participant's admission.

To protect and sustain the health, safety and welfare of waiver participants, Paramedical Services providers must be awake, alert and present during the scheduled hours of service and immediately available to the participant. Participants authorized for more than 360 hours a month of combined State Plan (such as IHSS services), WPCS, and/or Paramedical services benefits, must receive that care from two or more State Plan (such as IHSS) and/or WPCS providers. A Paramedical Service provider will not be paid to work more than 12 combined hours per day.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as an IHSS in compliance with state and federal law. Any services provided prior to the provider's enrollment as a paramedical service provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

Neither the Waiver Agency nor DHCS will authorize direct care services, or any combination of direct care and protective supervision services, exceeding 24 hours of care per day under this waiver, regardless of the funding source. Direct care services are defined in the "Additional Needed Information" section of this Waiver. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

Waiver participants whose complex medical care needs meet the acute hospital facility LOC, requiring frequent evaluation and/or intervention by an RN or LVN who is skilled and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's current primary care physician, are not eligible for this service. This requirement is compliant with the California Business and Professions Code, §2725.

Overtime:
On October 1, 2013, the United States Department of Labor published the Final Rule on applying the FLSA to domestic service providers which went into effect on February 1, 2016. FLSAs new overtime rule requires overtime (time and a half) pay for WPCS, paramedical service, and/or IHSS providers when they work more than 40 hours in a workweek. The workweek begins at 12 a.m. on Sunday, and ends at 11:59 p.m. the following Saturday. A single provider who works for a single participant can work up to 70-hours and 45-minutes of combined WPCS, paramedical services, and IHSS hours in one workweek. A single provider who works for multiple participants cannot work more than 66 hours in one workweek. WPCS hours will continue to be subject to a maximum work day of 12 combined hours. Each provider must establish a regular workweek schedule for each participant they serve, not to exceed the 70-hours and 45-minutes of WPCS, paramedical services, and IHSS hours combined, and not to exceed the participant's authorized weekly and monthly hours.

Travel Time:
Beginning February 1, 2016, WPCS providers who work for more than one participant may be eligible for travel time up to 7 hours per workweek. If an individual provider works over 40 hours in one workweek, travel time will be paid at time and a half. Travel time is the time it takes to travel directly from one participant to another on the same day to provide WPCS only or a combination of WPCS, paramedical services, and IHSS.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	IHSS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Paramedical Service

Provider Category:
Individual

Provider Type:

IHSS Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBA Waiver Standards of Participation

Welfare and Institution Code, Div. 9, Part 3, Chpt.3, Art. 7; CA Dept. of Social Services, Social Services Standards Manual, Service Program No. 7, In-Home Support Services (https://www.cdss.ca.gov/inforesources/letters-regulations/legislation-and-regulations/adult-services-regulations)

Overtime:
On October 1, 2013, the United States Department of Labor published the Final Rule on applying the FLSA to domestic service providers which went into effect on February 1, 2016. FLSAs new overtime rule requires overtime (time and a half) pay for WPCS, paramedical service, and/or IHSS providers when they work more than 40 hours in a workweek. The workweek begins at 12 a.m. on Sunday, and ends at 11:59 p.m. the following Saturday. A single provider who works for a single participant can work up to 70-hours and 45-minutes of combined WPCS, paramedical services, and IHSS hours in one workweek. A single provider who works for multiple participants cannot work more than 66 hours in one workweek. WPCS hours will continue to be subject to a maximum work day of 12 combined hours. Each provider must establish a regular workweek schedule for each participant they serve, not to exceed the 70-hours and 45-minutes of WPCS, paramedical services, and IHSS hours combined, and not to exceed the participant's authorized weekly and monthly hours.

Travel Time:
Beginning February 1, 2016, WPCS providers who work for more than one participant may be eligible for travel time up to 7 hours per workweek. If an individual provider works over 40 hours in one workweek, travel time will be paid at time and a half. Travel time is the time it takes to travel directly from one participant to another on the same day to provide WPCS only or a combination of WPCS, paramedical services, and IHSS.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

At the time of service request and modification

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

Assistive technology includes equipment or systems that are used to increase, maintain, or improve functional capabilities of participants, and/or enhance an individual's independence in performing activities of daily living (ADLs) and health related tasks. For the purposes of this waiver, Assistive Technology is limited to the following ADLs and health related tasks:
1. Bathing
2. Dressing and grooming
3. Toileting
4. Transferring
5. Eating
6. Communication
7. Medication Management

Determinations of an individual's functional capabilities will be completed by the CMT RN.

Assistive Technology includes services that directly assists a participant in the selection, acquisition, or use of medical necessity Assistive Technology, including:
1. Evaluation of the participant to determine the functional impact Assistive Technology would have on their ability to perform the ADLs and/or health related tasks identified above;
2. Training the participant and/or caregivers to use the Assistive Technology in the customary environment of the participant;
3. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; as well as maintaining, repairing, or replacing assistive technology devices at the end of their expected lifetime specified by the manufacturer;
4. Selecting, designing, fitting, customizing, adapting assistive devices; and
5. Costs associated with delivery and repairs of the items allowable under this service.

Examples of Assistive Technology include:
• Augmented communication devices (Example: Speech-to-Text devices/software)
• Emergency alert adaptations (Examples: blinking lights triggered by a smoke alarm)
• Telephone adaptive devices not available from the telephone company
• Tablets

Requested Assistive Technology must be for the least costly alternative to meet the individual's needs and must be related to an assessed functional need that is included in a participant's POT.

Assistive Technology does not include, any of the following costs:
• Devices that are considered experimental
• Animal support and assistance (i.e. service and/or therapy pets)
• Entertainment or recreational equipment/technology not specifically addressing and/or adapted for an assessed need
• Technology/devices used for employment, business, or educational purposes
• Service costs to Internet service, telephone service, utilities, etc.

Assistive Technology costs cannot exceed $2,500 per calendar year, and unused balances do not "roll over" to the following year(s).

Prior authorization by DHCS is required before purchasing Assistive Technology, and the following information must be submitted with the TAR and documented in the participant's case record:
1. The item is medical necessity to preserve the Waiver Participant's health, functional ability, and reach maximum independence, thereby minimizing or slowing the Waiver participant's elevation to a higher level of care and avoiding more costly institutionalization.
2. The Waiver Participant's assessment must identify the medical need for the Assistive Technology, including how it is a medical necessity support if the Waiver Participant is to remain in the community, and the care plan specifies the required item.
3. Proof of request and denial from other sources that provide Assistive Technology, including Medi-Cal state plan, Medicare, private insurance, Regional Center, school district, the Department of Rehabilitation, utility companies, community based organizations, etc.
4. At least two bids/cost estimates for Assistive Technology that costs over $500.

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

This waiver service is only authorized for individuals age 21 and over. All medical necessity Assistive Technology services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME Provider
Agency	HCBS Benefit Provider
Individual	HCBS Waiver Nurse Provider - RN
Agency	Professional Corporation
Agency	Non-Profit Agency
Agency	HHA

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

DME Provider

Provider Qualifications

License *(specify):*

W&I 14043.15, 14043.2, 14043.25, 14043.26
CCR Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)

Certificate *(specify):*

Other Standard *(specify):*

Business license appropriate for the services purchased.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

HCBS Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An HCBS Benefit Provider agency is a local government provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled in Medi-Cal as an HCBS Benefit Provider agency, and meets and maintains the SOP minimal qualifications for an HCBS Benefit Provider agency.

Minimum qualifications and requirements for an HCBS Benefit Provider agency functioning as an HCBS Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

3. Is experienced in providing HCBS and support to the elderly and/or persons with disabilities living in the community.

4. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Comprehensive Care Management services; and at least annually, requires CMT staff and supervisors to review the HCBA Waiver and Waiver Agency Contract Scope of Work HCBS requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the HCBA Benefit Provider agency.

5. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

6. Is responsible for the maintenance of waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

7. Employs licensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver who maintain a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California. Licensed person permitted to provide HCBS are:

a. Registered Nurse (RN pursuant to Chapter 6 (commencing with §2700) of Division 2 of the Business and Professions Code)

b. Licensed Clinical Social Worker (LCSW pursuant to Business & Professions Code, Division 2, Chapter 14, Article 4)

8. May employ the following unlicensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver:

a. Social Worker with at least a Master's Degree (MSW)

b. Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a

HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services that do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide HCBS consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

4. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation Definitions

a. “HCBA Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBA Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBA Waiver RN services” means case management or private duty nursing services, as described in the HCB waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by a HCBA Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To sustain and protect the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBA Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBA Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBA Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBA Waiver RN
The initial HCBA Waiver provider enrollment application shall be accompanied by all of the following documentation:

Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

A. Current Basic Life Support (BLS) certification.

B. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

C. An HCBA Waiver RN must provide Assistive Technology consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

C. An HCBA Waiver RN must provide Assistive Technology consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide HCBS to Waiver participants under the terms of the HCBA Waiver:

1. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

2. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

3. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

4. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as a HCBA Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or, if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as an HCBA Waiver provider must provide DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State’s Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration (California Corporations Code §13401(b)). The Professional Corporation must notify DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to DHCS upon enrollment and upon request. The Professional Corporation must notify DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render HCBA Waiver services to Waiver participants, as requested and authorized, and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS. The Professional Corporation must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum

hours of work experience for each of its licensed persons for inspection and review by DHCS.

6. A Professional Corporation must provide HCBS consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

1. Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:
The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS within 30 days of the

change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Assistive Technology consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health and Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transition Services are non-recurring set-up expenses at the time of enrollment into the Waiver for individuals who are transitioning from a licensed health care facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board.

Community transition services can include:
1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
4. One-time services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses; and
6. Activities to assess, arrange for, and procure needed resources.

Goods and/or services that are the legal responsibility of a property owner are not allowable; and, community transition services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

Community transition goods and services are identified during the person-centered development of the participant's POT to meet the unique need(s) of the participant. The POT must also include validation that the goods and services cannot be obtained from other sources.

The Waiver Agency or DHCS will approve the service after all requested documentation has been received and reviewed. In areas where there is a Waiver Agency, the Waiver Agency oversees the administration of the service and submits all of the medical documentation and invoices for approval and reimbursement.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

The participant may choose to receive Community Transition Services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Main. Optional Additional Needed Information.

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

For individuals who are transitioning from a licensed health care facility to a living arrangement in a private residence where the person is directly responsible for their own living expenses, community transition services are payable up to a total lifetime maximum amount of $5,000.00.

The only exception to the lifetime maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond the participant's control.

Community transition services must be necessary to protect and sustain the health, welfare, and safety of the participant outside of an institution; without which the participant would be unable to move to the private residence and/or require re-institutionalization.

This waiver service is only authorized for individuals age 21 and over. All medical necessity Community Transition Services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Waiver Nurse Provider - RN
Agency	Non-Profit Agency
Agency	HHA
Agency	HCBS Benefit Provider
Agency	Professional Corporation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or community-based residence by and HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBA Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBA Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBA Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2.000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. A HCBS Waiver RN must provide Community Transition services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2.000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. A HCBS Waiver RN must provide Community Transition services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:
1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS within 30 days of the

change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Community Transition waiver services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

HCBS Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An HCBS Benefit Provider agency is a local government provider that employs individuals who provide HCBS services approved under the HCBA Waiver, is enrolled in Medi-Cal as an HCBS Benefit Provider agency, and meets and maintains the SOP minimal qualifications for an HCBS Benefit Provider agency.

Minimum qualifications and requirements for an HCBS Benefit Provider agency functioning as an HCBA Waiver Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the program must have:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

3. Is experienced in providing HCBS and long-term support to the elderly and/or persons with disabilities living in the community.

4. Is responsible for providing training and/or in-services to staff eligible to provide HCBS Waiver services; and at least annually, requires CMT staff and supervisors to review the HCBA Waiver. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the HCBA Benefit Provider agency.

5. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

6. Is responsible for the maintenance of waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

7. Employs licensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver who maintain a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California. Licensed person permitted to provide community transition services are:

a. Registered Nurse (RN pursuant to Chapter 6 (commencing with §2700) of Division 2 of the Business and Professions Code)

b. Licensed Clinical Social Worker (LCSW pursuant to Business & Professions Code, Division 2, Chapter 14, Article 4

8. May employ the following unlicensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver:

a. Social Worker with at least a Master's Degree (MSW)

b. Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW.

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services who do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide HCBS consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide HCBS to Waiver participants under the terms of the HCBA Waiver:

1. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

2. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

3. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

4. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as a HCBA Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as an HCBA Waiver provider must provide DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State’s Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration (California Corporations Code §13401(b)). The Professional Corporation must notify DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to DHCS upon enrollment and upon request. The Professional Corporation must notify DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render HCBA Waiver services to Waiver participants, as requested and authorized, and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS. The Professional Corporation must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum

hours of work experience for each of its licensed persons for inspection and review by DHCS.

6. A Professional Corporation must provide HCBS consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Comprehensive Care Management

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Comprehensive Care Management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals enrolled in the HCBA Waiver, by responding to a participant's multiple and changing needs, and playing a pivotal role in accessing and coordinating required services from across multiple delivery systems, regardless of the funding source.

Comprehensive Care Management is only provided to HCBA Waiver participants by a qualified CMT comprised of an RN and a Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW. Both members of the CMT must be directly employed or contracted by the Waiver Agency. The CMT works with the participant, legal representative/legally responsible adult and/or circle of support to identify and coordinate State Plan and Waiver services, and other resources necessary to enable the participant to transition to the community and/or remain in their own home.

HCBA Waiver participants may choose to be involved in all aspects of the design, delivery, and modification of their services and be able to determine when, where and how they receive services. The CMT works with the participant, legal representative/legally responsible adult(s), circle of support, and current primary care physician in developing goals and identifying a course of action to respond to the assessed needs and individual circumstances and desires of the participant, and in the development of the participant's current primary care physician-signed POT. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services scope, frequency and duration as identified in the POT. Participants may request a review of their service plan at any time.

Comprehensive Care Management includes approval of medical necessity Waiver services and assisting Waiver participants with coordination of waiver services, other Medi-Cal services, and other needed resources regardless of funding source. When a waiver participant is enrolled a Managed Care plan (MCP), the MCP is responsible for providing the beneficiary Medi-Cal services covered by the plan, as well as Comprehensive Case Management, including Coordination of Care Services (MCP Boilerplate Contract, Exh. A, Attachment 11). In order to fulfill these responsibilities, the Waiver Agency and MCP must work collaboratively and promptly exchange all relevant information regarding the beneficiary, their health care needs, services, and efforts to obtain non Medi-Cal related assistance. The MCPs and Waiver Agencies are authorized to share this beneficiary information with each other because they are both DHCS contractors in the DHCS administration of the Medi-Cal program, with Business Associate Agreements, and they are sharing the information with each other as part of their contractual duties. (45 CFR §164.502(a)(1)(ii), 164.502(a)(3) and 164.506(c).) The MCP and Waiver Agency may, but are not required to, enter into Memorandums of Understanding (MOU) documenting the information sharing obligations and procedures. MCPs and Waiver Agencies cannot delay the sharing of information based on the lack of an MOU. If a Waiver Agency is unable to timely obtain beneficiary information from an MCP, the Waiver Agency must promptly notify DHCS of that fact in writing, providing information regarding the efforts made by the Waiver Agency to obtain the information from the MCP.

Comprehensive Care Management services are intended to increase participants' access to HCBS to stabilize them in the community; and include an initial face-to-face comprehensive nursing and psychosocial assessment; monthly service plan monitoring through face-to-face, or telephonic contact by the CMT; coordination of both waiver and state plan services in collaboration with the participant's Medi-Cal Managed Care Plan, as appropriate; integration within the local community; and ongoing comprehensive reassessments at least every 365 days that provide information about each participant's service needs. The CMT is also responsible for the development, implementation, and periodic evaluations of the written participant centered service plans.

Under the Comprehensive Care Management service, the CMT establishes a care coordination schedule based upon the needs and acuity of the participant as determined by their initial LOC Assessment and subsequent reassessments.

The CMT will coordinate all services by providers involved in the participants' care by providing the following components of Care Management:
• Assess medical needs including diagnosis, functional and cognitive abilities, and environmental and social needs;
• Care planning to mitigate risk and assist in adjusting care plans as appropriate;
• Service plan implementation, coordination and monitoring delivery and quality of services;
• Ongoing Waiver participant contact (including a monthly face-to-face, or telephonic visit) to monitor for changes in health, social, functional and environmental status; and
• Annual face-to-face visits; reassessments; and care plan updates.

The Waiver Agency receives a flat rate payment per member each month for the provision of the Comprehensive Care Management services, which is based upon the assessed case management acuity level of the participant. Only Waiver Agencies are able to bill for and provide the Comprehensive Care Management waiver service.

Comprehensive Care Management services under the waiver differ from the scope and nature of case management services under the State Plan and in areas without a Waiver Agency. Comprehensive Care Management services are concentrated on the coordination and monitoring of cost-effective, quality HCBS for the waiver participant, while in areas without a Waiver Agency, case management services are concentrated on referrals to providers and coordinating services.

Comprehensive Care Management Services for Private Duty Nursing Services Authorized for Medi-Cal Beneficiaries Under the Age of 21

For purposes of this section only, "Private Duty Nursing" means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)

The Waiver Agency is required to provide Comprehensive Care Management Services, including, upon the request of an HCBA Waiver enrolled EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal PDN services, arranging for all approved Medi-Cal PDN nursing services desired by the beneficiary. Medi-Cal PDN services include PDN services approved by the California Children's Services (CCS) Program. Upon the request of a Waiver enrolled EPSDT eligible Medi-Cal beneficiary for whom Medi-Cal PDN services have been approved, the Waiver Agency shall use one or more HHA, INP, or any combination thereof, in providing Comprehensive Care Management Services to arrange for all approved PDN services desired by the beneficiary. The Waiver Agency's Comprehensive Care Management Services include:
• Requesting from DHCS, and upon receipt, providing to a Waiver enrolled EPSDT eligible Medi-Cal beneficiary approved for Medi-Cal PDN services, information about the number of PDN hours that the beneficiary is approved to receive.
• Contacting enrolled HHAs and enrolled INPs to seek approved PDN services on behalf of a Waiver enrolled EPSDT eligible Medi-Cal beneficiary for whom Medi-Cal PDN services have been approved as an EPSDT benefit;
• Identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Medi-Cal provider;
• Working with HHAs and enrolled INPs to jointly provide PDN services to a Waiver enrolled EPSDT eligible Medi-Cal beneficiary approved to receive PDN services, as needed.

The Waiver Agency has primary responsibility to provide Comprehensive Care Management, which includes the Case Management Services described above, to a Waiver participant who is an EPSDT eligible Medi-Cal beneficiary approved to receive PDN services by Medi-Cal fee-for-service, and not by a Medi-Cal Managed Care Plan or CCS. The CCS Program has primary responsibility to provide Case Management for approved PDN services for a Medi-Cal beneficiary who is EPSDT eligible and for whom CCS has approved PDN services for treatment of a CCS condition. When a Medi-Cal Managed Care Plan has approved PDN services for an enrolled EPSDT eligible Medi-Cal beneficiary, the Managed Care Plan has primary responsibility to provide Case Management for approved PDN services. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved PDN services, an EPSDT eligible Medi-Cal beneficiary who is approved for Medi-Cal PDN services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be a Managed Care Plan, CCS, or the Waiver Agency) to request Case management for PDN services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

The participant may choose to receive Comprehensive Care Management either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Main. Optional Additional Needed Information.

The Waiver Agency receives a flat rate payment per member each month for the provision of the Comprehensive Care Management services, which is based upon the assessed case management acuity level of the participant. Only Waiver Agencies are able to bill for and provide the Comprehensive Care Management waiver service.

Comprehensive Care Management services under the waiver differ from the scope and nature of case management services under the State Plan and in areas without a Waiver Agency. Comprehensive Care Management services are concentrated on the coordination and monitoring of cost-effective, quality HCBS for the waiver participant, while in areas without a Waiver Agency, case management services are concentrated on referrals to providers and coordinating services.

Comprehensive Care Management Services for Private Duty Nursing Services Authorized for Medi-Cal Beneficiaries Under the Age of 21

For purposes of this section only, "Private Duty Nursing" means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)

The Waiver Agency is required to provide Comprehensive Care Management Services, including, upon the request of an HCBA Waiver enrolled EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal PDN services, arranging for all approved Medi-Cal PDN nursing services desired by the beneficiary. Medi-Cal PDN services include PDN services approved by the California Children's Services (CCS) Program. Upon the request of a Waiver enrolled EPSDT eligible Medi-Cal beneficiary for whom Medi-Cal PDN services have been approved, the Waiver Agency shall use one or more HHA, INP, or any combination thereof, in providing Comprehensive Care Management Services to arrange for all approved PDN services desired by the beneficiary. The Waiver Agency's Comprehensive Care Management Services include:
• Requesting from DHCS, and upon receipt, providing to a Waiver enrolled EPSDT eligible Medi-Cal beneficiary approved for Medi-Cal PDN services, information about the number of PDN hours that the beneficiary is approved to receive.
• Contacting enrolled HHAs and enrolled INPs to seek approved PDN services on behalf of a Waiver enrolled EPSDT eligible Medi-Cal beneficiary for whom Medi-Cal PDN services have been approved as an EPSDT benefit;
• Identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Medi-Cal provider;
• Working with HHAs and enrolled INPs to jointly provide PDN services to a Waiver enrolled EPSDT eligible Medi-Cal beneficiary approved to receive PDN services, as needed.

The Waiver Agency has primary responsibility to provide Comprehensive Care Management, which includes the Case Management Services described above, to a Waiver participant who is an EPSDT eligible Medi-Cal beneficiary approved to receive PDN services by Medi-Cal fee-for-service, and not by a Medi-Cal Managed Care Plan or CCS. The CCS Program has primary responsibility to provide Case Management for approved PDN services for a Medi-Cal beneficiary who is EPSDT eligible and for whom CCS has approved PDN services for treatment of a CCS condition. When a Medi-Cal Managed Care Plan has approved PDN services for an enrolled EPSDT eligible Medi-Cal beneficiary, the Managed Care Plan has primary responsibility to provide Case Management for approved PDN services. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved PDN services, an EPSDT eligible Medi-Cal beneficiary who is approved for Medi-Cal PDN services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be a Managed Care Plan, CCS, or the Waiver Agency) to request Case management for PDN services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

The participant may choose to receive Comprehensive Care Management either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Main. Optional Additional Needed Information.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Professional Corporation
Agency	HHA
Agency	HCBS Benefit Provider
Agency	Non-Profit Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Comprehensive Care Management

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals, who provide Case Management services approved under the HCBA Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide Case Management services to waiver participants under the terms of the HCBA Waiver:

a. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

c. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

d. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as a HCBS Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or, if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as HCBS Waiver providers must provide DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State’s Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession.

Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration. (California Corporations Code §13401(b)).

The Professional Corporation must notify the DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to the DHCS upon enrollment and upon request. The Professional Corporation must notify the DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS. The professional corporation must notify the DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing Case Management services to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

6. Provide Case Management services consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

a. Develop the POT consistent with the assessment of the waiver participant and the participant's current primary care physician's orders for care. Collaborate with the waiver participant's current primary care physician in the development of the POT to address the waiver participant's medical care needs. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services, and the expected outcomes.

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the care provided under the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT to reflect the medical needs of the waiver participant as determined by the participant's current primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the participant and/or legal representative/legally responsible adult, and the participant's current primary care physician no less frequently than once every six months.

c. Submit the POT to DHCS for approval of HCBA Waiver enrollment and services.

i. DHCS will review the initial and periodic POTs and supporting documents to determine that the requested waiver services are medical necessity and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or legal representative/legally responsible adult(s) participated in the development of the POT and was informed of their free choice to select qualified providers.

ii. DHCS may request additional documentation supporting the medical necessity of the services described in the POT and discuss any necessary or suggested revisions of the POT with the provider. Modifications to the POT can only be made with the approval of the participant's current primary care physician and the participant and/or legal representative/legally responsible adult(s). DHCS will not complete enrollment of the participant in the HCBA Waiver or authorize requested waiver services until the POT accurately reflects the participant's need for services to safely live in their home or community based setting, the providers of those services, any goals for the participant, and identifies and describes the plan to correct any safety issues.

d. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Comprehensive Care Management

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Comprehensive Care Management

Provider Category:

Agency

Provider Type:

HCBS Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An HCBS Benefit Provider agency is a local government provider that employs individuals who provide Comprehensive Case Management services approved under the HCBA Waiver, is enrolled in Medi-Cal as an HCBS Benefit Provider agency, and meets and maintains the SOP minimal qualifications for an HCBS Benefit Provider agency.

Minimum qualifications and requirements for an HCBS Benefit Provider agency functioning as an HCBA Waiver Case Management Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

3. Is experienced in providing home and community-based Case Management services and support to the elderly and/or persons with disabilities living in the community.

4. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Comprehensive Care Management services; and at least annually, requires CMT staff and supervisors to review the HCBA Waiver and Waiver Agency Contract Scope of Work Comprehensive Care Management requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the HCBA Benefit Provider agency.

5. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

6. Is responsible for the maintenance of waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

7. Employs licensed persons permitted to provide Comprehensive Case Management services to waiver participants under the terms of the HCBA Waiver who maintain a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California. Licensed person permitted to provide Comprehensive Case Management are:

a. Registered Nurse (RN pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code)

b. Licensed Clinical Social Worker (LCSW pursuant to Business & Professions Code, Division 2, Chapter 14, Article 4

8. May employ the following unlicensed persons permitted to provide Comprehensive Case Management services to waiver participants under the terms of the HCBA Waiver:

a. Social Worker with at least a Master's Degree (MSW)

b. Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing Case Management services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services that do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing Case Management services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide Case Management services consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

a. Develop the POT consistent with the assessment of the waiver participant and the participant's current primary care physician's orders for care. Collaborate with the waiver participant's current primary care physician in the development of the POT to address the waiver participant's medical care needs. The POT will identify all of the services needed to meet the needs of the waiver participant, the providers of those services, and the expected outcomes.

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT to determine the efficacy of the care provided under the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT to reflect the medical needs of the waiver participant as determined by the participant's current primary care physician. The POT must be updated and signed by the participant and/or legal representative/legally responsible adult, the Waiver Agency, the Waiver service providers, and the participant's current primary care physician, no less frequently than once every six months.

c. During the participant Waiver enrollment process, submit the POT to DHCS for approval of HCBA Waiver enrollment. DHCS will review the initial and periodic POTs and supporting documents to determine that the requested waiver services are medical necessity and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or legal representative/legally responsible adult(s) participated in the development of the POT and was informed of their freedom to choose a qualified providers.

DHCS may request additional documentation supporting the medical necessity of the services described in the POT and discuss any necessary or suggested revisions of the POT with the provider. Modifications to the POT can only be made with the approval of the participant's current primary care physician and the participant and/or legal representative/legally responsible adult(s). DHCS will not complete enrollment of the participant in the HCBA Waiver or authorize requested waiver services until the POT accurately reflects the participant's need for medical necessity waiver services to safely live in their home or community based setting, the providers of those services, any goals for the participant, and

identifies and describes the plan to correct any safety issues.

d. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing Case Management services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services that do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing Case Management services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide Case Management services consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

a. Develop the POT consistent with the assessment of the waiver participant and the participant's current primary care physician's orders for care. Collaborate with the waiver participant's current primary care physician in the development of the POT to address the waiver participant's medical care needs. The POT will identify all of the services needed to meet the needs of the waiver participant, the providers of those services, and the expected outcomes.

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT to determine the efficacy of the care provided under the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT to reflect the medical needs of the waiver participant as determined by the participant's current primary care physician. The POT must be updated and signed by the participant and/or legal representative/legally responsible adult, the Waiver Agency, the Waiver service providers, and the participant's current primary care physician, no less frequently than once every six months.

c. During the participant Waiver enrollment process, submit the POT to DHCS for approval of HCBA Waiver enrollment. DHCS will review the initial and periodic POTs and supporting documents to determine that the requested waiver services are medical necessity and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or legal representative/legally responsible adult(s) participated in the development of the POT and was informed of their freedom to choose a qualified providers.

DHCS may request additional documentation supporting the medical necessity of the services described in the POT and discuss any necessary or suggested revisions of the POT with the provider. Modifications to the POT can only be made with the approval of the participant's current primary care physician and the participant and/or legal representative/legally responsible adult(s). DHCS will not complete enrollment of the participant in the HCBA Waiver or authorize requested waiver services until the POT accurately reflects the participant's need for medical necessity waiver services to safely live in their home or community based setting, the providers of those services, any goals for the participant, and

identifies and describes the plan to correct any safety issues.

d. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Comprehensive Care Management

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business License, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides HCBS to the elderly and persons with disabilities.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Case Management Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Has filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based Case Management services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Case Management services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render Case Management services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing Case Management services to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of all requirements of the Waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS within 30 days of a change

of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

10. Employs qualified professional providers to provide HCBA Waiver Case Management services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

11. The Non-Profit Organization must provide Case Management services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience as follows:

A. Develop the POT consistent with the assessment of the waiver participant and the current primary care physician's orders for care. Collaborate with the waiver participant's current primary care physician in the development of the POT to address the waiver participant's medical care needs. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services and the expected outcomes.

B. Facilitate the process of assessing the Waiver participant at the frequency described in the POT for progress and response to the care provided under the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT as directed by the participant's current primary care physician to reflect the medical needs of the waiver participant, as determined by the participant's current primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the participant and/or legal representative/legally responsible adult, and the participant's current primary care physician, no less frequently than, once every six months.

C. Submit the POT to DHCS for approval of HCBA Waiver enrollment and services.

a. The POT and supporting documents will be reviewed by DHCS to determine that the requested waiver services are medical necessity and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or legal representative/legally responsible adult(s) participated in the development of the POT and was informed of their freedom to choose qualified providers.

b. DHCS may request additional documentation supporting the medical necessity of the services described in the POT, and the Case Management Provider will discuss any necessary or suggested revisions of the POT with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). DHCS will not complete enrollment of the applicant in the HCBA Waiver or authorize requested waiver services until the POT is revised by the Case Manager to accurately reflect the participant's needs, services, providers, goals and documents the correction of any safety issues.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the POT signed by the participant's current primary care physician. Provide the participant with education and resources regarding self-advocacy and systems change.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the POT signed by the participant's current primary care physician. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Continuous Nursing and Supportive Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Continuous Nursing and Supportive Services (CNSS) are provided to waiver participant's residing in a CLHF and must be available to waiver participants 24 hours a day, 7 days a week. The per diem rate paid for CNSS does not include room and board.

CNSS are a collection of services included in a per diem rate based on the waiver participant's level of care. CNSS will include nursing services provided by an RN, LVN, and a Certified Nurse Assistant (CNA) or persons with similar training and experience. As part of the per diem rate there must be a minimum of a CNA (or unlicensed equivalent provider) and an LVN, awake, alert, and on duty at all times to provide care for the residents of the CLHF. At no time, can two CNAs or persons with similar training and experience be solely responsible for waiver participants, as there must always be an RN or LVN present and "on duty." Nursing personnel shall not be assigned housekeeping or dietary duties.

RN:
1. An RN will be available on-call to the CLHF with a response time of thirty minutes or less at all times that an RN is not on the premises.
2. The RN shall visit each waiver participant for a minimum of two hours, twice a week, or longer as necessary to meet the participant's care needs.

LVN:
1. An LVN shall be in the CLHF and "on duty" at any time that an RN is not onsite.

CNA or equivalent unlicensed provider:
1. A CNA or persons with similar training and experience may be available in the CLHF to assist the skilled nursing staff (RN and LVN) to meet the requirement of at least two (2) staff members awake, alert and on duty at all times to provide care for residents of the CLHF.

The CNSS per diem rate will also include:
- Medical supervision
- Coordinate participant care
- Pharmacy consultation
- Dietary consultation
- Social Services
- Recreational services
- Transportation to and from medical appointments
- Housekeeping and laundry services
- Cooking and shopping

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

Neither the Waiver Agency, nor DHCS, will authorize additional waiver services that are duplicative of services included in the CNSS per diem rate.

Neither the Waiver Agency nor DHCS will authorize direct care services, or any combination of direct care and protective supervision services, exceeding 24 hours of care per day under this waiver, regardless of the funding source. Direct care services are defined in the "Additional Needed Information" section of this Waiver. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

This waiver service is only authorized for individuals age 21 and over. All medical necessity CNSS for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CLHF

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Continuous Nursing and Supportive Services

Provider Category:

Agency

Provider Type:

CLHF

Provider Qualifications

License *(specify):*

HSC §§1250et seq.
CCR Title 22, §§51246 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

As an HCBA Waiver CNSS Provider, the CLHF will provide a home like setting for individuals enrolled in the HCBA Waiver who chooses a CLHF as their place of residence. As a HCBA Waiver Service Provider of CNSS, the CLHF shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

As a HCBA Waiver CNSS Provider, a CLHF is a residential setting with a non-institutional, homelike environment, having no more than eighteen beds with an option for a private unit. The CLHF provides CNSS that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care, pharmacy, dietary, social, recreational and services. The CNSS are provided to waiver participants who meet the medical level of care criteria of the waiver and are persons whose medical condition(s) are within the scope of licensure for a CLHF as follows: persons who are mentally alert and physically disabled, persons who have a diagnosis of terminal illness, persons who have a diagnosis of a life-threatening illness or persons who are catastrophically and severely disabled. The primary need of CLHF residents shall be the availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. The per diem rate paid for CNSS does not include room and board.

Legal Authority and Requirements:

1. A CLHF shall be licensed in accordance with Health & Safety Code §§1250(i), 1267.12, 1267.13, 1267.16, 1267.17, and 1267.19, and shall provide skilled nursing waiver services in accordance with CCR, Title 22, §§51003 and 51344 and the HCBA Waiver document.

2. A CLHF must be enrolled as an HCBA Waiver provider and shall meet the standards specified in the CCR, Title 22, §§51200(a), 51000.30 through 51000.55, as well as all other laws and regulations applicable to Medi-Cal providers.

Any subsequently adopted laws or regulations that exceed the CLHF waiver provider participation requirements shall supersede the CLHF waiver provider requirements set forth in the waiver and shall be applicable to all CLHF waiver providers.

Physical Plant and Health and Safety Requirements:

1. To protect the health and safety of the Waiver participant, the physical plant of the CLHF shall conform to the Health and Safety Code §1267.13, as described in part in the following:

A. Obtain and maintain a valid fire clearance from the appropriate authority having jurisdiction over the facility, based on compliance with state regulations concerning fire and life safety, as adopted by the State Fire Marshall.

B. The setting shall be in a homelike, residential setting. The facility shall provide sufficient space to allow for the comfort, autonomy, dignity and privacy of each resident and adequate space for the staff to complete their tasks.

C. Common areas in addition to the space allotted for the residents' sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities of the residents in a homelike and communal manner.

D. The residents' individual sleeping quarters will allow sufficient space for safe storage of their property, possessions, control of personal resources, and furnishings and still permit access for the staff to complete their necessary health care functions. Not more than two residents shall share a bedroom with an option for a private unit. Residents who choose to reside with a roommate will have their choice of a roommates.

E. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene and personal needs of each resident and the ability of the staff to render care without spatial limitations or compromise. No bathroom shall be accessed only through a resident's bedroom.

F. The setting will be maintained in good repair and shall provide a safe, clean, and healthy environment at all times. All persons shall be protected from hazards throughout the premises. The setting will be physically accessible.

A CLHF Providing CNSS under the HCBA Waiver shall do the following:

1. A CLHF shall employ a variety of providers and render services as indicated below. The individuals providing CNNS waiver services to Waiver participants shall meet all licensing requirements as specified in California Business and Professions Code and all the SOP of the HCBA Waiver. The primary category of CNNS provided by a CLHF is nursing services, which must be available to Waiver clients on a 24 hours, 7 days a week basis.

Nursing Services:

1. Pursuant to Health and Safety Code §1267.13(o)(2)(B) and (o)(2)(C), a CLHF shall provide nursing services provided by an RN, LVN, and a CNA or persons with similar training and experience. There shall be a minimum of two (2) staff members, as describe under a, b, and c awake, alert, and on duty at all times to provide for the care of residents of the CLHF. At no time, can two CNAs or persons with similar training and experience be solely responsible for patients, as there must always be an RN or LVN present and "on duty." No nursing personnel shall be assigned housekeeping or dietary duties, such as meal preparation.

A. RN
i. An RN will be available on-call to the setting with a response time of thirty minutes or less at all times that an RN is not on the premises.
ii. The RN shall visit each resident for a minimum of two hours, twice a week, or longer as necessary to meet the resident's care needs.

B. LVN
i. An LVN shall be in the setting and "on duty" at any time that an RN is not in the setting.

C. CNA or equivalent unlicensed provider
i. A CNA or persons with similar training and experience may be available in the setting to assist the skilled nursing staff (RN and LVN) to meet the requirement of two staff members in the setting.

2. The setting shall provide appropriately qualified staff in sufficient numbers to meet the resident's care needs.

Other Health Related Services:

1. In addition to the skilled nursing services and pursuant to Health and Safety Code §1250(i) and 1267.13, a CLHF will provide or arrange for the following basic services to be provided to individuals enrolled in the Waiver, as part of the per diem rate paid to CLHF CNSS waiver providers:

- Medical supervision
- Case Management, (in areas of the state where there are no HCBA Waiver Agencies)
- Pharmacy consultation
- Dietary consultation
- Social Services
- Recreational services
- Transportation to and from medical appointments
- Housekeeping and laundry services
- Cooking and shopping

Health and Safety Code §1267.13(o)(3) states, “The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.” In addition to nursing care, a facility shall provide professional, administrative, or supportive personnel for the health, safety, and special needs of the patients.

Pursuant to Health and Safety Code §1267.12, “All persons admitted or accepted for care by the CLHF shall remain under the care of a primary care physician or surgeon who shall see the resident at least every 30 calendar days or more frequently if required by the resident’s medical condition.”

As a Waiver service provider, the CLHF will assess each HCBA Waiver participant for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individuals at the request of the individual. The CLHF will establish a POT to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the CLHF’s per diem rate under this waiver. The CLHF will be responsible for arranging for the following services, which may include but are not limited to:

- Counseling services provided by a Licensed Clinical Social Worker;
- Occupational therapy provided by an Occupational Therapist
- Physical therapy provided by a Physical Therapist
- Speech therapy provided by a Speech Therapist
- Education and training of the Waiver participant to self-direct care needs and/or the education and training of their identified caregivers (who are not CLHF employees) on their care needs
- Assessment for and repair of Durable Medical Equipment and
- State Plan Personal Care Services or WPCS as described in the approved Waiver when off site from the CLHF if such care is not duplicative of care required to be provided to the waiver participant by the CLHF (i.e., not for care to and from medical appointments). State Plan or WPCS providers will not be paid for care that is duplicative of the care being provided by the CLHF.

Documentation:

1. All Waiver services rendered by the CLHF shall require prior approval and re-approval.

2. Each CLHF shall maintain a medical record chart for each waiver participant in residence. This medical record shall include documentation regarding all contact made with CLHF professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to appropriate DHCS or Waiver Agency staff for any scheduled or unscheduled visit. All CLHF documentation shall be maintained in compliance with the applicable Federal and State laws, Medi-Cal Provider Standards of Participation, and shall be retained by the CLHF for three years. The CLHF shall also maintain records to document compliance with the nursing staff requirements (see Nursing Services above) of these standards of participation and have those records available for inspection or review by DHCS or the Waiver Agency upon request at any time.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with the Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As a licensed CLHF CNNS Waiver service provider, and pursuant to Health and Safety Code §1267.13(o)(5), the CLHF shall confirm all CLHF staff receive training regarding care appropriate for each waiver participant’s diagnoses and their individual needs. The supervisor(s) of licensed and unlicensed personnel will arrange for the training of their staff to be provided by the CLHF. Provision of the training to CLHF staff is a requirement to be enrolled as a Waiver provider and is not reimbursed by either Medi-Cal, Waiver Agency or the Waiver.

2. Pursuant to the Policies and Procedures of the CLHF and as a Waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective, scope of practice. CDPH Licensing & Certification (L&C) will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

3. As determined by L&C, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the CLHF and enrolled in this waiver.

2. Pursuant to the Policies and Procedures of the CLHF and as a Waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective, scope of practice. CDPH Licensing & Certification (L&C) will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

3. As determined by L&C, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the CLHF and enrolled in this waiver.

Health and Safety Code §1267.13(o)(3) states, “The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.” In addition to nursing care, a facility shall provide professional, administrative, or supportive personnel for the health, safety, and special needs of the patients.

Pursuant to Health and Safety Code §1267.12, “All persons admitted or accepted for care by the CLHF shall remain under the care of a primary care physician or surgeon who shall see the resident at least every 30 calendar days or more frequently if required by the resident’s medical condition.”

As a Waiver service provider, the CLHF will assess each HCBA Waiver participant for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individuals at the request of the individual. The CLHF will establish a POT to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the CLHF’s per diem rate under this waiver. The CLHF will be responsible for arranging for the following services, which may include but are not limited to:

- Counseling services provided by a Licensed Clinical Social Worker;
- Occupational therapy provided by an Occupational Therapist
- Physical therapy provided by a Physical Therapist
- Speech therapy provided by a Speech Therapist
- Education and training of the Waiver participant to self-direct care needs and/or the education and training of their identified caregivers (who are not CLHF employees) on their care needs
- Assessment for and repair of Durable Medical Equipment and
- State Plan Personal Care Services or WPCS as described in the approved Waiver when off site from the CLHF if such care is not duplicative of care required to be provided to the waiver participant by the CLHF (i.e., not for care to and from medical appointments). State Plan or WPCS providers will not be paid for care that is duplicative of the care being provided by the CLHF.

Documentation:

1. All Waiver services rendered by the CLHF shall require prior approval and re-approval.

2. Each CLHF shall maintain a medical record chart for each waiver participant in residence. This medical record shall include documentation regarding all contact made with CLHF professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to appropriate DHCS or Waiver Agency staff for any scheduled or unscheduled visit. All CLHF documentation shall be maintained in compliance with the applicable Federal and State laws, Medi-Cal Provider Standards of Participation, and shall be retained by the CLHF for three years. The CLHF shall also maintain records to document compliance with the nursing staff requirements (see Nursing Services above) of these standards of participation and have those records available for inspection or review by DHCS or the Waiver Agency upon request at any time.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with the Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As a licensed CLHF CNNS Waiver service provider, and pursuant to Health and Safety Code §1267.13(o)(5), the CLHF shall confirm all CLHF staff receive training regarding care appropriate for each waiver participant’s diagnoses and their individual needs. The supervisor(s) of licensed and unlicensed personnel will arrange for the training of their staff to be provided by the CLHF. Provision of the training to CLHF staff is a requirement to be enrolled as a Waiver provider and is not reimbursed by either Medi-Cal, Waiver Agency or the Waiver.

2. Pursuant to the Policies and Procedures of the CLHF and as a Waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective, scope of practice. CDPH Licensing & Certification (L&C) will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

3. As determined by L&C, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the CLHF and enrolled in this waiver.

2. Pursuant to the Policies and Procedures of the CLHF and as a Waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective, scope of practice. CDPH Licensing & Certification (L&C) will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

3. As determined by L&C, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the CLHF and enrolled in this waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

HCBA Waiver Standards of Participation

DD/CNC, Non-Ventilator Dependent Services are provided to waiver participants who require 24-hour personal care, developmental services, and nursing supervision, are non-ventilator dependent and are developmentally disabled. Waiver participants must be certified by a physician as requiring continuous skilled nursing care. Waiver participants who are ventilator dependent may not receive DD/CNC, Non-Ventilator Dependent Services. Only individuals with developmental disabilities are eligible to receive Developmentally Disabled/Continuous Nursing Care (DD/CNC) services; however, similar continuous nursing services are available to HCBA Waiver participants without a developmental disability, including services provided to ventilator and non-ventilator dependent participants residing in Congregate Living Health Facilities receiving Continuous Nursing Services.

An ICF/DD-CN Providing DD/CNC Non-Ventilator Dependent Waiver Services:

An ICF/DD-CN shall employ a variety of providers and render services as indicated below. The individuals providing DD/CNC Non-Ventilator Dependent Waiver services to participants shall meet all licensing requirements as specified in the Business and Professions Code and the SOPs of the HCBA Waiver. The primary services provided by an ICF/DD-CNC are continuous skilled nursing care and developmental disability services and support, which must be available to participants on a 24-hour, 7-days per week basis.

Nursing Services:

1. Sufficient RN and LVN staffing to allow a minimum of four (4) hours per participant per day of non-duplicated skilled nursing, with a minimum of two (2) hours of the four (4) hours being non- duplicated RN staffing. All LVN staffing must be supervised by an RN who is available by telephone at all time.

2. Participants residing in an ICF/DD-CN residence must have available 24-hour skilled nursing services provided by or under the direct supervision of an RN. As required under California Business and Professions Code §2725, an LVN may render services under the supervision of an RN when the RN is not physically present, within their scope of practice.

3. A minimum of one RN and one LVN in the facility and awake at all time.

4. All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

5. Skilled nursing care includes:

A. Assistance with ADLs and IADLs
B. Ventilator, tracheostomy and respiratory care
C. IV therapy
D. Feeding and elimination care (including tubes)
E. Medication administration
F. Skin care

Other Health Related Services:

1. In addition to skilled nursing services, an ICF/DD-CN shall provide or arrange for the following basic services, as described on a participant's care plan, to be provided to individuals enrolled in the waiver, as part of the per diem rate paid to ICF/DD-CN Waiver providers:

• Medical supervision
• Pharmacy consultation
• Dietary consultation
• Social services
• Recreational services
• Transportation to and from necessary medical appointments
• Housekeeping and laundry services
• Cooking and shopping

• Any developmentally disabled-related services as specified in the participant's service plan.

2. Each waiver participant will be assessed for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individual at the request of the individual. The ICF/DD-CN will establish a POT (see Appendix D-1 for service plan information) to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the IDCF/DD-CN's per diem rate under this waiver. The ICF/DD-CN will be responsible for arranging for such services, including counseling, physical, occupational or speech therapy, education and training for the waiver participant and/or caregivers, assessment for and repair of durable medical equipment and off-site personal care services.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

DD/CNC, non-ventilator dependent services are limited to the following:

As stated above under "Service Definition," continuous (24-hour) skilled nursing care and other necessary medical, nursing and developmental services as needed by the waiver participant:

1. Sufficient RN and LVN staffing to allow a minimum of four(4) hours per participant per day of non-duplicated skilled nursing with a minimum of two (2) hours of the four(4) hours per participant per day being of non-duplicated RN staffing. All LVN staffing must be supervised by an RN who is available by telephone at all times.

2. Participants residing in an ICF/DD-CN must receive 24-hour skilled nursing services provided by or under the direct supervision of an RN. As required under California Business and Professions Code §2725, an LVN may render services under the supervision of an RN when the RN is not physically present, within their scope of practice.

3. A minimum of one RN or one LVN must be in the facility and awake at all times.

4. All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

5. The following nursing care needs are included within the scope of continuous nursing:

A. Assistance with ADLs and IADLs
B. Ventilator, tracheostomy and respiratory care
C. IV therapy
D. Feeding and elimination care (including tubes)
E. Medication administration
F. Skin care

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

This waiver service is only authorized for individuals age 21 and over. All medical necessity DD/CNC, Non-Ventilator Dependent Services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intermediate Care Facility for the Developmentally Disabled / Continuous Nursing (ICF/DD-CN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services

Provider Category:

Agency

Provider Type:

Intermediate Care Facility for the Developmentally Disabled / Continuous Nursing (ICF/DD-CN)

Provider Qualifications

License *(specify):*

Licensed as an ICF/DD-N (license is suspended in order to enroll as an ICF/DD-CN waiver provider)

Certificate *(specify):*

Enrolled in the Medi-Cal program as an ICF/DD-CN

Other Standard *(specify):*

HCBA Waiver Standards of Participation

As a HCBA Waiver Service Provider of Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator, the ICF/DD-CN will provide a home-like setting for individuals enrolled in the HCBA Waiver who choose an ICF/DD-CN as their place of residence. As a Waiver Service Provider, the ICF/DD-CN shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

An ICF/DD-CN is a residential facility licensed and regulated by the Department of Public Health, with a non-institutional, homelike environment and provides inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care including pharmacy, dietary, social, recreational and other services. These services are provided to waiver participants who meet the medical level of care criteria of the HCBA Waiver and are persons whose medical condition(s) are within the scope of practice for an ICF/DD-CN as follows: persons who are developmentally disabled with physical and mental disabilities that preclude independent living and self-care. Such persons may be diagnosed with a terminal illness or a life-threatening illness or may be catastrophically and severely disabled. The primary need of ICF/DD-CN residents shall be the availability of skilled nursing care on a continuous basis.

Legal Authority and Requirements:

1. An ICF/DD-CN shall be licensed as an ICF/DD-CN in accordance with Health and Safety Code §1250(e) and (h), 1265 et.al., 1266 et.al. and1268.6; and CCR, Title 22, Division 5, Chapter 8, Article 2; and shall provide skilled nursing waiver services in accordance with the CCR, Title 22, §51003 and 51344 and the approved waiver document.

2. An ICF/DD-CN must be enrolled as a Medi-Cal HCBA Waiver provider, and shall also meet the standards specified in Health and Safety Code §1250(m), and CCR, Title 22, §51200(a) and 51003.30 through 51000.55. Any subsequent adopted laws or regulations that exceed the ICF/DD-CN waiver provider participant requirements shall supersede the specified CCR sections and shall be applicable to all ICF/DD-CN providers.

Physical Plant and Health and Safety Requirements:

1. To protect the health and safety of the Waiver participate, the physical plant of the ICF/DD-CN shall conform to the requirements of CCR, Title 22, Division 5, Chapter 8, Article 5, as described in part in the following:

A. Must meet all requirements of the federal ICF/MR Conditions of Participation, Physical Environment [42 CFR §483.470(a)(1) through (k)(2)].

B. Each ICF/DD-CN must submit an initial emergency plan for evacuation and sheltering in place, no later than 30 days following the signing of the provider contract or agreement. The emergency plan will be reviewed, revised as necessary and be submitted annually to the California Department of Public Health (CDPH) coordinator for review and approval.

i. The plan will include detailed written plans and procedures to meet all potential emergencies and disasters [42 CFR §483.75(m) and 483.470(h); Health and Safety Code §1336.3(b); CCR, Title 22, §73929(a) and (b)].

ii. The provider's "External Disaster Plan" should address those types of emergencies relevant to the residence and its geographical location; the needs of the individuals served; and the highest risks for the residence's area. The plan must consider all of the following: transportation needs, sources of emergency utilities and supplies, procedures for assigning and recalling staff, procedures for moving participants from damaged areas of the residence, provisions for the conversion of useable space, procedure for emergency transfers of patients, evacuation routes, emergency phone numbers of physicians, health

facilities and local fire and Emergency Medical Technician (EMT) personnel, procedures for maintaining a record of participant movement and the method of sending all pertinent personal and medical information with them, security of the residence, procedures for the emergency discharge of participants, and provisions for prompt medical assessment and treatment of participants and staff as needed.

iii. Each provider is encouraged to consult with local emergency planning officials to confirm that their plan does not conflict with the city and/or county plans.

C. Obtain and maintain a valid fire clearance from the appropriate authority having jurisdiction over the facility, based on compliance with state regulations concerning fire and life safety, as adopted by the State Fire Marshall.

D. The ICF/DD-CN shall be maintained as a homelike, residential setting with sufficient space to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks.

E. Common areas in addition to the space allotted for the residents' sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities of the residents.

F. Residents' sleeping quarters will allow sufficient space for safe storage of their property, possessions, and furnishings and still permit access for the staff to complete their necessary health care functions.

G. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene needs of each resident and the ability of the staff to render care without spatial limitations or compromise.

H. The facility will be maintained in good repair and shall provide a safe, clean, and healthy environment at all times. All persons shall be protected from hazards throughout the premises.

Documentation:

1. All Waiver services rendered by the ICF/DD-CN shall require approval and reapproval.

2. Each ICF/DD-CN shall maintain a medical record chart for each waiver participant in residence. This medical record shall include documentation regarding all participant contact made with facility professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to appropriate DHCS staff for any scheduled or unscheduled visit. All facility documentation shall be maintained in compliance with the applicable Federal and State laws, Medi- Cal, HCBA Waiver Provider Standards of Participation, and shall be retained by the facility for three years.

3. The ICF/DD-CN shall also maintain records to document that all requirements specified in this waiver have been met, including those requirements related to staffing of the facility.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with the Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As a contracted or enrolled HCBA Waiver provider, the ICF/DD-CN shall provide training regarding services appropriate for each waiver participant based upon the participant's care needs, to all facility staff. Appropriate in-house supervisors shall arrange for the training of their staff to be provided by the ICF/DD-CN. Provision of this training is a requirement to be a waiver provider and is not separately reimbursed by either Medi-Cal, the waiver.

2. Such training shall be conducted on a quarterly basis and shall be documented, including the information taught, attendees, and the qualifications of the instructor. The ICF/DD-CN is also

responsible for providing appropriate orientation for all new facility employees.

3. CDPH's Licensing and Certification Division will be responsible for determining if the policies and procedures for training of ICF/DD-CN staff are adequate to provide and sufficient care to residents and to maintain their health and safety.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification Division

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

DD/CNC, Ventilator Dependent Services are provided to waiver participants who require 24-hour personal care, developmental services, and nursing supervision, are ventilator dependent and are developmentally disabled.

Waiver participants must be certified by a physician as requiring continuous skilled nursing care and services must be available to waiver participants 24 hours a day, 7 days a week. Waiver participants who are non-ventilator dependent may not receive DD/CNC, Ventilator Dependent Services. Only individuals with developmental disabilities are eligible to receive Developmentally Disabled/Continuous Nursing Care (DD/CNC) services; however, similar continuous nursing services are available to HCBA Waiver participants without a developmental disability, including services provided to ventilator and non-ventilator dependent participants residing in Congregate Living Health Facilities receiving Continuous Nursing Services.

An ICF/DD-CN Providing Waiver Services:

1. An ICF/DD-CN shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to participants shall meet all licensing requirements as specified in the B&P Code and the SOPs of the HCBA Waiver. The primary services provided by an ICF/DD-CN are continuous skilled nursing care and developmental disability services and support, which must be available to participants on a 24-hour, 7-days per week basis.

Nursing Services:

1. Sufficient RN and LVN staffing to allow a minimum of four (4) hours per participant per day of non-duplicated skilled nursing with a minimum of two (2) hours of the four (4) hours being non- duplicated RN staffing. All LVN staffing must be supervised by an RN who is available by telephone at all time.

2. Participants residing in an ICF/DD-CN residence must have available 24-hour skilled nursing services provided by or under the direct supervision of an RN. As required under California Business and Professions Code §2725, an LVN may render services under the supervision of an RN when the RN is not physically present, within their scope of practice.

3. A minimum of one RN and one LVN in the facility and awake at all time.

4. All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

5. Skilled nursing care includes:

A. Assistance with ADLs and IADLs
B. Ventilator, tracheostomy and respiratory care
C. IV therapy
D. Feeding and elimination care (including tubes)
E. Medication administration
F. Skin care

Other Health Related Services:

1. In addition to skilled nursing services, an ICF/DD-CN shall provide or arrange for the following basic services, as described on a participant's care plan, to be provided to individuals enrolled in the waiver, as part of the per diem rate paid to ICF/DD-CN Waiver providers:

• Medical supervision
• Pharmacy consultation
• Dietary consultation
• Social services
• Recreational services
• Transportation to and from necessary medical appointments
• Housekeeping and laundry services
• Cooking and shopping

• Any developmentally disabled-related services as specified in the participant's service plan.

2. Each waiver participant will be assessed for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individual at the request of the individual. The ICF/DD-CN will establish a POT (see Appendix D-1 for service plan information) to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the IDCF/DD-CN's per diem rate under this waiver. The ICF/DD-CN will be responsible for arranging for such services, including counseling, physical, occupational or speech therapy, education and training for the waiver participant and/or caregivers, assessment for and repair of durable medical equipment and off-site personal care services.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

DD/CNC, ventilator dependent services are limited to the following:

As stated above under "Service Definition" and continuous (24-hour) skilled nursing care and other necessary medical, nursing and developmental services as needed by the waiver participant:

1. Sufficient RN and LVN staffing to allow a minimum of four(4) hours per participant per day of non-duplicated skilled nursing with a minimum of two (2) hours of the four(4) hours per participant per day being of non-duplicated RN staffing. All LVN staffing must be supervised by an RN who is available by telephone at all times.

2. Participants residing in an ICF/DD-CN must receive 24-hour skilled nursing services provided by or under the direct supervision of an RN. An LVN can render services under the supervision of an RN when the RN is not physically present, pursuant to California Business and Professions Code §2859.

3. A minimum of one RN or one LVN must be in the facility and awake at all times.

4. All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

5. The following nursing care needs are included within the scope of continuous nursing:

• Assistance with ADLs and IADLs
• Ventilator, tracheostomy and respiratory care
• IV therapy
• Feeding and elimination care (including tubes)
• Medication administration
• Skin care

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

This waiver service is only authorized for individuals age 21 and over. All medical necessity DD/CNC, Ventilator Dependent Services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	ICF/DD-CN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services

Provider Category:

Agency

Provider Type:

ICF/DD-CN

Provider Qualifications

License *(specify):*

Licensed as an ICF/DD-N (license is suspended to enroll as an ICF/DD-CN waiver provider)

Certificate *(specify):*

Enrolled in the Medi-Cal program as an ICF/DD-CN

Other Standard *(specify):*

HCBA Waiver Standards of Participation

As an HCBA Waiver Provider of Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services, the ICF/DD-CN will provide a home-like setting for individuals enrolled in the HCBA Waiver who choose an ICF/DD-CN as their place of residence. As a Waiver Service Provider, the ICF/DD-CN shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

An ICF/DD-CN is a residential facility with a non-institutional, homelike environment and provides inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care including pharmacy, dietary, social, recreational and other services for waiver participants who meet the medical level of care criteria of the HCBA Waiver and are persons whose medical condition(s) are within the scope of practice for an ICF/DD-CN as follows: persons who are developmentally disabled with physical and mental disabilities that preclude independent living and self-care. Such persons may be diagnosed with a terminal illness or a life-threatening illness or may be catastrophically and severely disabled. The primary need of ICF/DD-CN residents shall be the availability of skilled nursing care on a continuous basis.

Legal Authority and Requirements:

1. An ICF/DD-CN shall be licensed as an ICF/DD-N in accordance with Health and Safety Code §1250(e) and (h), 1265 et.al. 1266 et.al. and 1268.6; and CCR, Title 22, Division 5, Chapter 8, Article 2; and shall provide skilled nursing waiver services in accordance with the CCR, Title 22, §51003 and 51344 and the approved waiver document.

2. An ICF/DD-CN enrolled as a Medi-Cal Waiver provider, and shall meet the standards specified in Health and Safety Code §1250(m), the CCR, Title 22, §51200(a) and 51003.30 through 51000.55. Any subsequent adopted laws or regulations that exceed the ICF/DD-CN waiver provider participant requirements shall supersede the specified CCR sections and shall be applicable to all ICF/DD-CN providers.

Physical Plant and Health and Safety Requirements:

1. To protect the health and safety of the Waiver participant, the physical plant of the ICF/DD-CN shall conform to the CCR, Title 22, Division 5, Chapter 8, Article 5, as described in part in the following:

A. Must meet all requirements of the federal ICF/MR Conditions of Participation, Physical Environment [42 CFR §483.470(a)(1) through (k)(2)].

B. Each ICF/DD-CN must submit an initial emergency plan for evacuation and sheltering in place, no later than 30 days following the signing of the provider agreement. The emergency plan will be reviewed, revised as necessary and be submitted annually to the CDPH coordinator for review and approval.

i. The plan will include detailed written plans and procedures to meet all potential emergencies and disasters [42 CFR §483.75(m) and 483.470(h); Health and Safety Code § 1336.3(b); CCR, Title 22, §73929(a) and (b)].

ii. The provider’s “External Disaster Plan” should address those types of emergencies relevant to the residence and its geographical location; the needs of the individuals served; and the highest risks for the residence’s area. The plan must consider all of the following: transportation needs, sources of emergency utilities and supplies, procedures for assigning and recalling staff, procedures for moving participants from damaged areas of the residence, provisions for the conversion of useable space, procedure for emergency transfers of patients, evacuation routes, emergency phone numbers of physicians, health facilities and local fire and EMT personnel, procedures for maintaining a record of participant movement and the method of sending all pertinent personal and medial information with them, security

of the residence, procedures for the emergency discharge of participants, and provisions for prompt medical assessment and treatment of participants and staff as needed.

iii. Each provider is encouraged to consult with local emergency planning officials to confirm that their plan does not conflict with the city and/or county plans.

C. Obtain and maintain a valid fire clearance from the appropriate authority having jurisdiction over the facility, based on compliance with state regulations concerning fire and life safety, as adopted by the State Fire Marshall.

D. The ICF/DD-CN shall be maintained as homelike, residential setting with sufficient space to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks.

E. Common areas in addition to the space allotted for the residents' sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities of the residents.

F. Residents' sleeping quarters will allow sufficient space for safe storage of their property, possessions, and furnishings and still permit access for the staff to complete their necessary health care functions.

G. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene needs of each resident and the ability of the staff to render care without spatial limitations or compromise.

H. The facility will be maintained in good repair and shall provide a safe, clean, and healthy environment at all times. All persons shall be protected from hazards throughout the premises.

Documentation:

1. All Waiver services rendered by the ICF/DD-CN shall require approval and re-approval.

2. Each ICF/DD-CN shall maintain a medical record chart for each waiver participant in residence. This medical record shall include documentation regarding all participant contact made with facility professional personnel, current POTs, referral requests and outcomes of said
referrals and shall be available to appropriate DHCS staff for any scheduled or unscheduled visit. All facility documentation shall be maintained in compliance with the applicable Federal and State laws, Medi-Cal and HCBA Waiver Provider SOP, and shall be retained by the facility for three years.

3. The ICF/DD-CN shall also maintain records to document that all requirements specified in this waiver have been met, including those requirements related to staffing of the facility.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with the Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As an enrolled HCBA Waiver provider, the ICF/DD-CN shall provide training regarding services appropriate for each waiver participant based upon the participant's care needs, to all facility staff. Appropriate in-house supervisors shall arrange for the training of their staff to be provided by the ICF/DD-CN. Provision of this training is a requirement to be contracted or enrolled as a waiver provider and is not separately reimbursed by either Medi-Cal or the waiver.

2. Such training shall be conducted on a quarterly basis and shall be documented, including the information taught, attendees, and the qualifications of the instructor. The ICF/DD-CN is also responsible for providing appropriate orientation for all new facility employees.

3. CDPH's Licensing and Certification Division will be responsible for determining if the policies and

procedures for training of ICF/DD-CN staff are adequate to provide appropriate and sufficient care of residents and maintain their health and safety.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification Division

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

Environmental Accessibility Adaptations are those physical adaptations to the home, identified in the participant's POT, that are necessary to sustain the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the safety and welfare of the participant. All services shall be provided in accordance with applicable State or local building codes.

All Environmental Accessibility Adaptations are subject to prior approval. Requests for any modifications to a residence, which is not the property of the waiver recipient, shall be accompanied by written consent from the property owner for the requested modifications. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

If there is no written authorization from the owner, environmental accessibility will not be approved or compensated for residential care providers or rental units. To the extent possible, the participant will make modifications to the residence prior to occupation. Upon commencement of approved modifications, all parties will receive written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the participant ceases to reside at the residence.

All requests for Environmental Accessibility Adaptations submitted by a waiver provider should include the following:

1. Participant's current primary care physician's order specifying the requested equipment or service;

2. Physical or Occupational Therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The Physical or Occupational Therapy evaluation and report should contain at least the following:

A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary;

4. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and,

5. After all requested documentation has been received and reviewed, the provider overseeing the administration of the service submits all of the medical documentation and invoices for approval and reimbursement and a home visit has been conducted to determine the suitability of any requested equipment or service.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

Environmental Accessibility Adaptation services are payable up to a total lifetime maximum amount of $5,000. The only exceptions to the $5,000 total maximum are if the recipient's place of residence changes or the waiver participant's condition has changed so significantly that additional modifications are necessary to protect and sustain the health, welfare, and safety of the participant, or are necessary to enable the participant to function with greater independence in the home and without which the recipient would require institutionalization.

This waiver service is only authorized for individuals age 21 and over. All medical necessity Environmental Accessibility Adaptation services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-Profit Agency
Agency	Professional Corporation
Individual	HCBS Waiver Nurse Provider - RN
Agency	Durable Medical Equipment (DME) Provider
Agency	HCBS Benefit Provider
Agency	HHA

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor

the license status of its licensed employees and report any changes to DHCS within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Environmental Accessibility Adaptations waiver services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney Generals registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide waiver services to waiver participants under the terms of the HCBA Waiver:

a. Licensed Psychologists (See Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

c. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

d. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation that functions as a HCBA Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as HCBS Waiver providers must provide the Waiver Agency or DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State’s Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession.

Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration. (California Corporations Code §13401(b)).

The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to the Waiver Agency or DHCS upon enrollment and upon request. The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by the Waiver Agency or DHCS. The professional corporation must notify the Waiver or DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

6. A Professional Corporation must provide HCBS consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 4

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider--RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by an HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency shall annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS shall periodically confirm the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Environmental Accessibility Adaptation services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Environmental Accessibility Adaptation services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Durable Medical Equipment (DME) Provider

Provider Qualifications

License *(specify):*

W&I 14043.15, 14043.2, 14043.25, 14043.26
CCR Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)

Certificate *(specify):*

Other Standard *(specify):*

Business license appropriate for the services purchased.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

HCBS Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An HCBS Benefit Provider agency is a local government provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled in Medi-Cal as an HCBS Benefit Provider agency, and meets and maintains the SOP minimal qualifications for an HCBS Benefit Provider agency.

Minimum qualifications and requirements for an HCBS Benefit Provider agency functioning as an HCBS Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

3. Is experienced in providing HCBS and support to the elderly and/or persons with disabilities living in the community.

4. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Comprehensive Care Management services; and at least annually, requires CMT staff and supervisors to review the HCBA Waiver and Waiver Agency Contract Scope of Work HCBS requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the HCBA Benefit Provider agency.

5. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

6. Is responsible for the maintenance of waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

7. Employs licensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver who maintain a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California. Licensed person permitted to provide HCBS are:

a. Registered Nurse (RN pursuant to Chapter 6 (commencing with §2700) of Division 2 of the Business and Professions Code)

b. Licensed Clinical Social Worker (LCSW pursuant to Business & Professions Code, Division 2, Chapter 14, Article 4)

8. May employ the following unlicensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver:

a. Social Worker with at least a Master's Degree (MSW)

b. Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a

HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services that do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide HCBS consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

4. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code § 1725 et seq.; 22 CCR § 74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Facility Respite

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Facility Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence of, or need for, relief of those persons who normally provide care for the participant.

These services are provided in an approved out-of-home location to do all of the following:
1. Provide appropriate care and supervision to protect the participant's safety in the absence of family members;
2. Relieve family members from the constantly demanding responsibility of caring for a participant; and
3. Attend to the participant's medical needs and other ADL's, which would ordinarily be the responsibility of the primary caregiver or family member.

The need for Facility Respite Service is authorized based on the unique circumstance of each, individual participant and family, but should consider:
• Severity of the participant's disability and needs.
• Potential risk of institutionalization if respite services are not provided.
• Lack of access to informal support systems such as family, friends, community supports, etc.
• Lack of access to other sources of respite (e.g., Regional Center), because of waiting lists, remote/inaccessible location of services, etc.
• Presence of factors known to increase family stress, such as family size, presence of another child or family member with a disability, etc. and
• The perceived and expressed level of need for respite services by the primary caregiver or legally responsible adult; however, the perceived need for respite services, in the absence of any other factors, is not a sufficient indicator of the need for respite.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

The services under the HCBA Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. The HCBA Waiver is the payer of last resort, and medical necessity Facility Respite services may only be authorized as a Waiver service for participants under the age of 21 when it is not available to the individual through any other system, including 1915(i) state plan coverage, private insurance, etc.

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

Neither the Waiver Agency nor DHCS will authorize direct care services, or any combination of direct care and protective supervision services, exceeding 24 hours of care per day under this waiver, regardless of the funding source. Direct care services are defined in the "Additional Needed Information" section of this Waiver. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

Facility Respite services provided in a PDHC facility Transitional Health Care Needs Optional Service Unit, for waiver participants over the age of 21, is limited to no more than 30 intermittent or continuous whole calendar days per patient per calendar year.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PDHC
Agency	CLHF

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Respite

Provider Category:

Agency

Provider Type:

PDHC

Provider Qualifications

License *(specify):*

PDHC providers must be licensed and certified by the State of California and must meet the requirements specified in CCR, Title 22, §51184, 51242, 51242.1, 51340.1 and 51532.3; Health and Safety Code, §1760; and Welfare and Institutions Code, §14132.10.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

As a Waiver service provider, the PDHC will provide a home like setting for individuals enrolled in the HCBA Waiver who meet the requirements of Health and Safety Code §1760.2(a)-(c) and 1763.4(a)(3)(B), and choose a PDHC as their place of respite.

"Respite care" means day and 24-hour relief for the parent or guardian, and care for the patient. 24-hour inpatient respite care includes, but is not limited to, 24-hour nursing care, meals, socialization, and developmentally appropriate activities, and is limited to no more than 30 intermittent or continuous whole calendar days per patient per calendar year.

Facility-based respite services must provide all of the following services:
1. Medical
2. Nursing
3. Pharmacy
4. Nutrition
5. Socialization
6. Developmentally appropriate activities

Services that may be provided by a PDHC include, but are not limited to, any of the following:
1. Physical therapy
2. Developmental services
3. Occupational and speech therapy
4. Educational and psychological services
5. Respite care
6. Instruction for parents or guardians
7. Case management, if not otherwise available for the client

Legal Authority and Requirements:

As a Waiver service provider, the PDHC shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

1. A PDHC shall be licensed in accordance with Health and Safety Code §1760.2, 1760.6, 1267.13 and 1337 and shall provide skilled nursing waiver services in accordance with CCR, Title 22, §51003 and 51344 and the waiver document. To the extent that the waiver provisions conflict with the Welfare and Institutions Code statutory and implementing regulatory provisions governing availability of PDHC respite for individuals 22 and over, the waiver provisions and Health & Safety Code provisions allowing PDHC respite for individual 22 and over under specific circumstances shall prevail.

2. A PDHC must be enrolled as a Medi-Cal Waiver provider as required under state and federal Medicaid provider enrollment law, including but not limited to, 42 U.S.C. 1396a(78), 42 CFR Part 455, Subpart E, Welfare & Institutions Code, Division 1, Part 3, Chapter 7, Article1.3, and CCR, Title 22, Division 3, subdivision 1, Article 1. The PDHC must also sign a Waiver provider agreement.

3. Any subsequently adopted laws or regulations that exceed the PDHC waiver provider participation requirements shall supersede the PDHC waiver provider requirements and shall be applicable to all PDHC waiver providers.

The facility will be maintained in good repair and shall provide a safe, clean, and healthy environment at all times, and comport with physical plant requirements included in Health and Safety Code §1760 - 1763.4. All persons shall be protected from hazards throughout the premises.

A PDHC Providing Waiver Services:

As a provider of Waiver facility respite services, a PDHC shall employ a variety of providers and render

services as indicated below. The individuals providing waiver services to Waiver participants shall meet all licensing requirements as specified in California Business and Professions Code and all of the SOP of the HCBA Waiver. The primary category of service provided by a PDHC is nursing services, which must be available to Waiver participants consistent with their individual care needs.

The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.

Documentation:

The Waiver facility respite service provider will assess each HCBA Waiver enrolled individual for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individuals at the request of the individual, in accordance with the Waiver POT.

All Waiver respite services rendered by the PDHC require prior authorization and reauthorization in accordance with CCR, Title 22, §51003, and the terms of the Waiver.

The PDHC shall prepare a TAR and submit it to the Waiver Agency, or DHCS in areas of the state not covered by a Waiver Agency, for each waiver participant seeking to utilize PDHC facility-based respite. The initial TAR submitted by the PDHC shall include a copy of the POT signed by the participant's current primary care physician, as well as the PDHC’s current facility license. TARs submitted for reauthorization shall be accompanied by an updated primary care physician signed POT and a renewed facility license, as appropriate.

Each PDHC shall maintain a medical record chart for each waiver participant. This medical record shall include documentation regarding all contact made with PDHC professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to the CMT or HCBA Case Management provider for any scheduled or unscheduled visit. All PDHC documentation shall be maintained in compliance with the applicable Federal and State laws, and HCBA Waiver Provider Standards of Participation. The PDHC shall also maintain records to document that the nursing staff requirements of these SOP have been met and have those records available for inspection or review by the Waiver Agency or DHCS upon request at any time.

Quality Control/Quality Assurance:

Quality Control/quality assurance reviews will be in accordance with DHCS’ Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

As a licensed PDHC Waiver facility respite service provider, PDCH supervisors/administrators shall provide training regarding care appropriate for each waiver participant’s diagnoses and their individual needs, to all facility staff. The supervisor(s) of licensed and unlicensed personnel will arrange for the training of their staff to be provided by the PDHC. Providing training to PDHC staff is a requirement to be enrolled as a Waiver provider and is not reimbursed by either Medi-Cal, the Waiver Agency, or the Waiver.

Pursuant to the Policies and Procedures of the PDHC and as a Waiver provider, each category of nursing (RN, LVN, and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective scope of practice. California Department of Public Health Licensing and Certification (L&C) staff PDHC L&C will determine if the PDHC policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

As determined by L&C, the PDHC is responsible for the orientation and training of all staff that render care. This includes the review of new and existing PDHC policies and procedures and training and shall

be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the PDHC.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Respite

Provider Category:

Agency

Provider Type:

CLHF

Provider Qualifications

License *(specify):*

HSC §§1250et seq.
CCR Title 22, §§51246 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

As an HCBA Waiver Service Provider, the CLHF will provide a home like setting for individuals enrolled in the HCBA Waiver who chooses a CLHF as their place of respite. As a Waiver Service Provider, the CLHF shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

As a Medi-Cal Waiver Service Provider, a CLHF waiver facility respite provider is a residential or respite facility with a non- institutional, homelike environment, having no more than eighteen beds and provides inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care, pharmacy, dietary, social, recreational and services. The services are provided to waiver participants who meet the medical level of care criteria of the appropriate waiver and are persons whose medical condition(s) are within the scope of licensure for a CLHF as follows: persons who are mentally alert and physically disabled, persons who have a diagnosis of terminal illness, persons who have a diagnosis of a life-threatening illness or persons who are catastrophically and severely disabled. The primary need of CLHF participants shall be the availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis.

Legal Authority and Requirements:

1. A CLHF shall be licensed in accordance with Health and Safety Code §1250(i), 1267.12, and 1267.13, 1267.16, 1267.17, and 1267.19 and shall provide skilled nursing waiver services in accordance with CCR, Title 22, §51003 and 51344 and the waiver document.

2. A CLHF must be contracted or enrolled as a Medi-Cal Waiver provider and shall meet the standards specified in the CCR, Title 22, §51200(a), 51000.30 through 51000.55.

3. Any subsequently adopted laws or regulations that exceed the CLHF waiver provider participation requirements shall supersede the CLHF waiver provider requirements and shall be applicable to all CLHF waiver providers.

Physical Plant and Health and Safety Requirements:

1. To maintain and protect the health and safety of the Waiver participant, the physical plant of the CLHF shall conform to the Health and Safety §1267.13, as described in part in the following:

A. Obtain and maintain a valid fire clearance from the appropriate authority having jurisdiction over the facility, based on compliance with state regulations concerning fire and life safety, as adopted by the State Fire Marshall.

B. The facility shall be in a homelike setting. The facility shall provide sufficient space to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks.

C. Common areas in addition to the space allotted for the residents' sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities in a homelike and communal manner.

D. The individual sleeping quarters will allow sufficient space for safe storage of their property, possessions, and furnishings and still permit access for the staff to complete their necessary health care functions.

E. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene needs of each respite participant and the ability of the staff to render care without spatial limitations or compromise. No bathroom shall be accessed only through a resident's bedroom.

F. The facility will be maintained in good repair and shall provide a safe, clean, and healthy environment

at all times. All persons shall be protected from hazards throughout the premises.

A CLHF Providing Waiver Services:

1. As a provider of Waiver facility respite services, a CLHF shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to Waiver participants shall meet all licensing requirements as specified in California Business and Professions Code and all the SOP of the HCBA Waiver. The primary category of service provided by a CLHF is nursing services, which must be available to Waiver participants consistent with their individual care needs.

Nursing Services:

1. Pursuant to Health and Safety Code §1267.13(o)(2)(B) and (o)(2)(C), a CLHF shall provide nursing services provided by an RN, LVN, CNA, or persons with similar training and experience. There shall be a minimum of two staff members, as describe under a, b, and c awake, alert, and on duty at all times to provide for the participants of the CLHF. At no time, can two CNAs or persons with similar training and experience be solely responsible for patients, as there must always be a RN or LVN present and "on duty." No nursing personnel shall be assigned housekeeping or dietary duties, such as meal preparation.

A.RN
i. An RN will be available on-call to the facility with a response time of thirty minutes or less at all times that an RN is not on the premises.

ii.The RN shall visit each resident for a minimum of two hours, twice a week, or longer as necessary to meet the resident's patient care needs.

B. LVN
i. An LVN shall be in the facility and "on duty" at any time that a RN is not in the facility.

C. CNA or equivalent unlicensed provider

i. A CNA or persons with similar training and experience may be available in the facility to assist the skilled nursing staff (RN and LVN) to meet the requirement of two staff members in the facility.

2. The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.

Other Health Related Services:

1. In addition to the skilled nursing services and pursuant to Health and Safety Code §1250(i) and 1267.13, a CLHF will provide or arrange for the following basic services to be provided to individuals enrolled in the Waiver, as part of the per diem rate paid to CLHF waiver providers:

- Medical supervision
- Case Management, (in areas of the state where there are no HCBA Waiver Agencies)
- Pharmacy consultation
- Dietary consultation
- Social Services
- Recreational services
- Transportation to and from medical appointments
- Housekeeping and laundry services
- Cooking and shopping

Health and Safety Code §1267.13(o)(3) states, "The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs." In addition to nursing care, a facility shall provide professional, administrative, or supportive personnel for the health, safety, and special needs of the patients.

Pursuant to Health and Safety Code §1267.12, “All persons admitted or accepted for care by the CLHF shall remain under the care of a primary care physician or surgeon who shall see the resident at least every 30 calendar days or more frequently if required by the resident’s medical condition.”

The Waiver facility respite service provider will assess each HCBA Waiver enrolled individual for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individuals at the request of the individual. The CLHF will establish a POT to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the CLHF’s per diem rate under this waiver. The CLHF will be responsible for arranging for the following services, which may include but are not limited to:

- Counseling services provided by a Licensed Clinical Social Worker;
- Occupational therapy provided by an Occupational Therapist
- Physical therapy provided by a Physical Therapist
- Speech therapy provided by a Speech Therapist
- Education and training of the Waiver participant to self-direct their care needs and/or the education and training of their identified caregivers (who are not CLHF employees) on their care needs
- Assessment for and repair of Durable Medical Equipment and
- State Plan Personal Care Services or WPCS as described in the approved Waiver when off site from the CLHF if such care is not duplicative of care required to be provided to the waiver participant by the CLHF (i.e., not for care to and from medical appointments). State Plan or WPCS providers will not be paid for care that is duplicative of the care being provided by the CLHF.

Documentation:

1. All Waiver services rendered by the CLHF shall require prior authorization and reauthorization in accordance with CCR, Title 22, §51003.

2. A TAR shall be prepared by the CLHF and submitted to the Waiver Agency or DHCS for each waiver participant utilizing respite in a CLHF that renders Waiver services. The initial TAR for each waiver participant shall be accompanied by an RN developed assessment of care needs, and a POT signed by the participant’s current primary care physician. The initial TAR submitted by the CLHF shall include a copy of the current facility license. TARs submitted for reauthorization shall be accompanied by an updated primary care physician signed POT and a renewed facility license, as appropriate.

3. Each CLHF shall maintain a medical record chart for each waiver participant. This medical record shall include documentation regarding all contact made with CLHF professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to the CMT or HCBA Case Management provider for any scheduled or unscheduled visit. All CLHF documentation shall be maintained in compliance with the applicable Federal and State laws, HCBA Waiver Provider Standards of Participation, and shall be retained by the CLHF for three years. The CLHF shall also maintain records to document that the nursing staff requirements (see Nursing Services above) of these SOP have been met and have those records available for inspection or review by the Waiver Agency or DHCS upon request at any time.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with DHCS’ Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As a licensed CLHF Waiver facility respite service provider, and pursuant to Health and Safety Code §1267.13(o)(5), the CLHF shall provide training regarding care appropriate for each waiver participant’s diagnoses and their individual needs, to all facility staff. The supervisor(s) of licensed and unlicensed

personnel will arrange for the training of their staff to be provided by the CLHF. Providing training to CLHF staff is a requirement to be enrolled as a Waiver provider and is not reimbursed by either Medi-Cal, the Waiver Agency, or the Waiver.

2. Pursuant to the Policies and Procedures of the CLHF and as a Waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective scope of practice. CDPH L&C will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

3. As determined by L&C, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the CLHF and enrolled in this waiver.

Pursuant to Health and Safety Code §1267.12, “All persons admitted or accepted for care by the CLHF shall remain under the care of a primary care physician or surgeon who shall see the resident at least every 30 calendar days or more frequently if required by the resident’s medical condition.”

The Waiver facility respite service provider will assess each HCBA Waiver enrolled individual for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individuals at the request of the individual. The CLHF will establish a POT to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the CLHF’s per diem rate under this waiver. The CLHF will be responsible for arranging for the following services, which may include but are not limited to:

- Counseling services provided by a Licensed Clinical Social Worker;
- Occupational therapy provided by an Occupational Therapist
- Physical therapy provided by a Physical Therapist
- Speech therapy provided by a Speech Therapist
- Education and training of the Waiver participant to self-direct their care needs and/or the education and training of their identified caregivers (who are not CLHF employees) on their care needs
- Assessment for and repair of Durable Medical Equipment and
- State Plan Personal Care Services or WPCS as described in the approved Waiver when off site from the CLHF if such care is not duplicative of care required to be provided to the waiver participant by the CLHF (i.e., not for care to and from medical appointments). State Plan or WPCS providers will not be paid for care that is duplicative of the care being provided by the CLHF.

Documentation:

1. All Waiver services rendered by the CLHF shall require prior authorization and reauthorization in accordance with CCR, Title 22, §51003.

2. A TAR shall be prepared by the CLHF and submitted to the Waiver Agency or DHCS for each waiver participant utilizing respite in a CLHF that renders Waiver services. The initial TAR for each waiver participant shall be accompanied by an RN developed assessment of care needs, and a POT signed by the participant’s current primary care physician. The initial TAR submitted by the CLHF shall include a copy of the current facility license. TARs submitted for reauthorization shall be accompanied by an updated primary care physician signed POT and a renewed facility license, as appropriate.

3. Each CLHF shall maintain a medical record chart for each waiver participant. This medical record shall include documentation regarding all contact made with CLHF professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to the CMT or HCBA Case Management provider for any scheduled or unscheduled visit. All CLHF documentation shall be maintained in compliance with the applicable Federal and State laws, HCBA Waiver Provider Standards of Participation, and shall be retained by the CLHF for three years. The CLHF shall also maintain records to document that the nursing staff requirements (see Nursing Services above) of these SOP have been met and have those records available for inspection or review by the Waiver Agency or DHCS upon request at any time.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with DHCS’ Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As a licensed CLHF Waiver facility respite service provider, and pursuant to Health and Safety Code §1267.13(o)(5), the CLHF shall provide training regarding care appropriate for each waiver participant’s diagnoses and their individual needs, to all facility staff. The supervisor(s) of licensed and unlicensed

personnel will arrange for the training of their staff to be provided by the CLHF. Providing training to CLHF staff is a requirement to be enrolled as a Waiver provider and is not reimbursed by either Medi-Cal, the Waiver Agency, or the Waiver.

2. Pursuant to the Policies and Procedures of the CLHF and as a Waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective scope of practice. CDPH L&C will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

3. As determined by L&C, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the CLHF and enrolled in this waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family/Caregiver Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Family/Caregiver training services are training and counseling for families and/or unlicensed caregivers of waiver participants. Family members and voluntary members of the participant's circle of support are unpaid, backup caregivers that would provide care to the participant when a paid provider is not available. Family/Caregiver Training services include instruction about medical treatment, use of durable medical equipment, how to provide medical care services and specialized dietary plans for the participant in the absence of the paid care providers. All family training must be identified in the participant's current primary care physician signed POT.

Unlicensed caregivers (WPCS, paramedical, and IHSS) should be evaluated to determine specific training needs that will meet the participant's unique needs and the type of services to be provided. Training should also assist the family, participant, and/or circle of support in ensuring the unlicensed caregiver has the necessary skills, competencies and qualifications to provide those services. All unlicensed caregiver training must be included in the participant's current primary care physician signed POT.

Family/Caregiver Training services in the participant's home may be provided only by an RN. To render Family/Caregiver Training the provider must document the training that is needed and the process to meet the need, and submit the documentation with a request for training to the Waiver Agency/DHCS. Upon completion of the training, the provider will submit documentation of the training results to the Waiver Agency/DHCS.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

The participant may choose to receive Family/Caregiver Training either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Main. Optional Additional Needed Information.

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

This waiver service is only authorized for individuals age 21 and over. All medical necessity family/caregiver training services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HHA
Individual	HCBS Waiver Nurse Provider - RN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/Caregiver Training

Provider Category:
Agency
Provider Type:

HHA

Provider Qualifications
License *(specify):*

Health and Safety Code § 1725 et seq.; 22 CCR § 74600 et seq
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency
Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/Caregiver Training

Provider Category:
Individual
Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications
License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14
Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by and HCB Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another state’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Family Caregiver Training services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Family Caregiver Training services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medical Equipment Operating Expense

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Medical Equipment Operating Expenses are services necessary to prevent re-institutionalization of waiver participants who are dependent upon medical technology. Medical Equipment Operating Expenses must be described in the participant's POT. Medical Equipment Operating Expenses are limited to costs directly attributable to operation of life sustaining medical equipment in the participant's place of residence. For purposes of this waiver service, "life sustaining medical equipment" is defined as: mechanical ventilation equipment and positive airway pressure equipment, suction machines, feeding pumps, and infusion equipment. Notwithstanding this definition, in the event a specific medical need is identified and Medical Equipment Operating Expenses are requested in the POT, the Waiver Agency or DHCS will evaluate the request for this service and may grant exceptions to this definition.

A waiver service provider may submit a request for the authorization of this service to the Waiver Agency or DHCS for evaluation of the request. After the request has been approved, the waiver service provider may bill the Waiver Agency or Medi-Cal for this service. Upon the provider's receipt of payment, the provider will reimburse the monies to the participant.

In order to calculate the cost per unit of time, the authorization for waiver Medical Equipment Operating Expenses includes consideration of the type of equipment and frequency of use. Cost factors to operate electrical equipment are supplied by local utility companies and are based on a consideration of the equipment's size and voltage and amperage requirement.

The CMT or HCBA Case Management provider is responsible for notifying the local utility providers that the HCBA Waiver participant is an individual dependent upon life sustaining medical equipment. Documentation indicating that local utilities have been notified shall be kept in the participant's case record, and updated and revised when necessary by the CMT or HCBA Case Management provider.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

The minimum monthly claim for Medical Equipment Operating Expense is $20.00, the maximum is $75.00. Medical Equipment Operating Expenses are only allowable when there are no other possible payers of the medical equipment operating expenses.

This service is not available in a provider-operated residence such as a CLHF or ICF/DD/CN.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCBS Benefit Provider
Agency	Professional Corporation
Agency	Non-Profit Agency
Individual	HCBS Waiver Nurse Provider - RN
Agency	HHA

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:

Agency

Provider Type:

HCBS Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An HCBS Benefit Provider agency is a local government provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled in Medi-Cal as an HCBS Benefit Provider agency, and meets and maintains the SOP minimal qualifications for an HCBS Benefit Provider agency.

Minimum qualifications and requirements for an HCBS Benefit Provider agency functioning as an HCBS Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

3. Is experienced in providing HCBS and support to the elderly and/or persons with disabilities living in the community.

4. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Comprehensive Care Management services; and at least annually, requires CMT staff and supervisors to review the HCBA Waiver and Waiver Agency Contract Scope of Work HCBS requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the HCBA Benefit Provider agency.

5. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

6. Is responsible for the maintenance of waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

7. Employs licensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver who maintain a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California. Licensed person permitted to provide HCBS are:

a. Registered Nurse (RN pursuant to Chapter 6 (commencing with §2700) of Division 2 of the Business and Professions Code)

b. Licensed Clinical Social Worker (LCSW pursuant to Business & Professions Code, Division 2, Chapter 14, Article 4)

8. May employ the following unlicensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver:

a. Social Worker with at least a Master's Degree (MSW)

b. Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a

HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services that do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide HCBS consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

4. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide HCBS to Waiver participants under the terms of the HCBA Waiver:

1. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

2. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

3. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

4. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as a HCBS Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or, if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as an HCBS Waiver provider must provide DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State's Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration (California Corporations Code §13401(b)). The Professional Corporation must notify DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to DHCS upon enrollment and upon request. The Professional Corporation must notify DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render HCBA Waiver services to Waiver participants, as requested and authorized, and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS. The Professional Corporation must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum

hours of work experience for each of its licensed persons for inspection and review by DHCS.

6. A Professional Corporation must provide HCBS consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

1. Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:
The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS within 30 days of a change

of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Medical Equipment Operating Expense waiver services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney Generals registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider--RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by an HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBA Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Medical Equipment Operating Expense services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Medical Equipment Operating Expense services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response (PERS) Installation and Testing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

The Personal Emergency Response System (PERS) installation and testing service is for installation and testing of a PERS for participants who are at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to participants who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require routine supervision.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

This waiver service is only authorized for individuals age 21 and over. All medical necessity Personal Emergency Response System (PERS) installation and testing service for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME Provider
Agency	Professional Corporation
Agency	HHA
Agency	HCBS Benefit Provider
Individual	HCBS Waiver Nurse Provider - RN
Agency	Non-Profit Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Agency

Provider Type:

DME Provider

Provider Qualifications

License *(specify):*

W&I 14043.15, 14043.2, 14043.25, 14043.26
CCR Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)

Certificate *(specify):*

Other Standard *(specify):*

Business license appropriate for the services purchased.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide HCBS to Waiver participants under the terms of the HCBA Waiver:

a. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

c. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

d. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as an HCBS Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as HCB Waiver providers must provide the Waiver Agency or DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State’s Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession.

Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration. (California Corporations Code §13401(b)).

The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to the Waiver Agency or DHCS upon enrollment and upon request. The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by the Waiver Agency or DHCS. The professional corporation must notify the Waiver or DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing case management services to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by the Waiver Agency or DHCS.

6. A Professional Corporation must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code §1725 et seq.; 22 CCR §74600 et seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Agency

Provider Type:

HCBS Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An HCBS Benefit Provider agency is a local government provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled in Medi-Cal as an HCBS Benefit Provider agency, and meets and maintains the SOP minimal qualifications for an HCBS Benefit Provider agency.

Minimum qualifications and requirements for an HCBS Benefit Provider agency functioning as an HCBS Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

3. Is experienced in providing HCBS and support to the elderly and/or persons with disabilities living in the community.

4. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Comprehensive Care Management services; and at least annually, requires CMT staff and supervisors to review the HCBA Waiver and Waiver Agency Contract Scope of Work HCBS requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the HCBA Benefit Provider agency.

5. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

6. Is responsible for the maintenance of waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

7. Employs licensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver who maintain a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California. Licensed person permitted to provide HCBS are:

a. Registered Nurse (RN pursuant to Chapter 6 (commencing with §2700) of Division 2 of the Business and Professions Code)

b. Licensed Clinical Social Worker (LCSW pursuant to Business & Professions Code, Division 2, Chapter 14, Article 4)

8. May employ the following unlicensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver:

a. Social Worker with at least a Master's Degree (MSW)

b. Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a

HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services that do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide HCBS consistent with the participant's medical necessity services to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

4. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBA Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCB Waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by and HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor

the license status of its licensed employees and report any changes to DHCS within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney Generals registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

The PERS is a 24-hour emergency assistance electronic device that enables individuals at high risk of institutionalization to secure help in an emotional, physical, or environmental emergency. PERS services are limited to waiver participants who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and would otherwise require routine supervision.

The PERS is connected to the participant's telephone and programmed to signal a response center once a "help" button is activated. The participant may wear a portable "help" button permitting greater mobility. The response center is staffed with trained professionals who have access to the participant's profile and critical information. PERS staff will immediately attempt to contact the participant to determine if an emergency exists. If one does exist, the PERS staff contacts local emergency response services to request assistance.

The immediate response to a participant's request for assistance can help prevent unnecessary institutionalization of a waiver participant. PERS services will only be provided as a waiver service to a participant residing in a non-licensed environment.

PERS are individually designed to meet the needs and capabilities of the participant. The following services are allowed:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company; and
10. Other electronic devices/services designed for emergency assistance.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. Prior authorization for PERS services must be obtained by a waiver service provider through DHCS or the Waiver Agency.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

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

PERS services are limited to waiver participants who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and would otherwise require routine supervision.

This waiver service is only authorized for individuals age 21 and over. All medical necessity PERS for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME Provider
Agency	HHA
Agency	HCBS Benefit Provider
Agency	Non-Profit Agency
Agency	Professional Corporation
Individual	HCBS Waiver Nurse Provider - RN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

DME Provider

Provider Qualifications

License *(specify):*

W&I 14043.15, 14043.2, 14043.25, 14043.26
CCR Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)

Certificate *(specify):*

Other Standard *(specify):*

Business license appropriate for the services purchased.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code §1725 et seq.; 22 CCR §74600 et seq

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

HCBS Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An HCBS Benefit Provider agency is a local government provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled in Medi-Cal as an HCBS Benefit Provider agency, and meets and maintains the SOP minimal qualifications for an HCBS Benefit Provider agency.

Minimum qualifications and requirements for an HCBS Benefit Provider agency functioning as an HCBS Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

3. Is experienced in providing HCBS and support to the elderly and/or persons with disabilities living in the community.

4. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver Comprehensive Care Management services; and at least annually, requires CMT staff and supervisors to review the HCBA Waiver and Waiver Agency Contract Scope of Work HCBS requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the HCBA Benefit Provider agency.

5. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

6. Is responsible for the maintenance of waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

7. Employs licensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver who maintain a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California. Licensed person permitted to provide HCBS are:

a. Registered Nurse (RN pursuant to Chapter 6 (commencing with §2700) of Division 2 of the Business and Professions Code)

b. Licensed Clinical Social Worker (LCSW pursuant to Business & Professions Code, Division 2, Chapter 14, Article 4)

8. May employ the following unlicensed persons permitted to provide HCBS to waiver participants under the terms of the HCBA Waiver:

a. Social Worker with at least a Master's Degree (MSW)

b. Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by an MSW

The minimum qualification and requirements for an HCBS Benefit Provider agency functioning as a

HCBA Waiver Service Provider are:

1. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The HCBS Benefit Provider agency must maintain records of licensing for inspection and review by DHCS upon request. The HCBS Benefit Provider agency must notify DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

2. Employ unlicensed persons as specified above who will render waiver services that do not require a licensed professional to provide them, as requested and authorized, and who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing HCBS services to the elderly and/or persons with disabilities living in the community. The HCBS Benefit Provider agency must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

3. Provide HCBS consistent with the participant's services of medical necessity to safely live in their home or community based setting, taking into consideration the current primary care physician's orders and the POT, within the scope of the licensed person's scope of practice as follows:

4. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Non-Profit Agency/Organization is a California service entity organized and operated under the United States Internal Revenue Code §501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBA Waiver contract and Medi-Cal Provider requirements may provide HCBA Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

Minimum qualifications and requirements for a Non-Profit Organization functioning as an HCBA Waiver Service Provider are:
1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program has:

a. A Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community; or

b. At least five (5) years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. Maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. Is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. Is responsible for providing training and/or in-services to staff eligible to provide HCBA Waiver services and at least annually reviews the HCBA Waiver services requirements. Training of HCBA Waiver service providers must be specific to the conditions and care of HCBA Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBA Waiver.

8. Is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), Licensed Psychologist, and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within their scope of licensure in the State of California.

b. Has documented work experience that includes, at least, a minimum of 1,000 hours experience in providing services to the elderly and/or persons with disabilities living in the community.

10. The Non-Profit Organization must maintain records and documentation of all requirements of the waiver/SOP for inspection and review by DHCS. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS within 30 days of the

change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS.

11. Employs qualified professional providers to provide HCBA Waiver services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Have at least 1,000 hours work experience providing services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS.

12. A Non-Profit Organization must provide Medical Equipment Operating Expense waiver services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney Generals registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide HCBS approved under the HCBA Waiver, is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation.

The following are the licensed persons permitted to provide HCBS to Waiver participants under the terms of the HCBA Waiver:

1. Licensed Psychologists (See California Business and Professions Code §2900, et seq.) operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See California Business and Professions Code §4996, et seq.); operating a Professional Corporation pursuant to California Corporations Code §13400, et seq.,

c. Marriage and Family Therapists (MFT) (See California Business and Professions Code §4980, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq. and,

d. Registered Nurse (RN) (See California Business and Professions Code §2725, et seq.) operating as a Professional Corporation pursuant to California Corporations Code §13400, et seq.

Minimum qualification and requirements for a Professional Corporation functioning as a HCBS Waiver Service Provider are:

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to California Corporations Code §13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation.

2. The Professional Corporation must maintain good standing as a domestic or foreign professional corporation while the professional corporation is enrolled as an HCBA Waiver provider.

3. All Professional Corporations enrolling as HCBS Waiver providers must provide the Waiver Agency or DHCS a Certificate of Status of Good Standing to do business in the State of California (available from the Secretary of State’s Office) and a current Certificate of Registration (pursuant to California Corporations Code §13401(b)) provided by the governmental agency regulating the profession.

Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the Certificate of Registration. (California Corporations Code §13401(b)).

The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to its Good Standing status or its Certificate of Registration within five (5) business days of the change.

4. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California, and provide a copy of that license to the Waiver Agency or DHCS upon enrollment and upon request. The Professional Corporation must notify the Waiver Agency or DHCS in writing of any change to the status of its license to practice business within five (5) business days of the change.

5. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

a. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by the Waiver Agency or DHCS. The professional corporation must notify the Waiver or DHCS in writing of any change in licensure status of its licensed employees within five (5) days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1,000 hours of experience in providing case management services to the elderly and/or persons with disabilities living in the community. The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by the Waiver Agency or DHCS.

6. A Professional Corporation must provide PERS consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by and HCB Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meets waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Private Duty Nursing - Including Home Health Aide and Shared Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Private Duty Nursing (PDN) services are individual and continuous care (in contrast to part-time or intermittent care) provided by a licensed nurse (RN or LVN) or a Certified Home Health Aide (CHHA) employed by a HHA within the scope of state law. Private Duty Nursing is all skilled nursing interventions that are within the scope of the RN or LVN's licensure, or CHHA's certification, ordered by the participant's primary care physician, documented on the POT and authorized by the Waiver Agency, nor where there is no Waiver Agency, DHCS staff. Services are provided to a waiver participant in their home, home-like environment or an approved out-of-home setting compliant with the Home and Community-Based Settings requirements.

Shared PDN services are provided to two participants who live at the same residence. Shared PDN services are provided only on request and agreement of the involved participants and/or authorized representative(s).

A HCBS RN provides supervision and monitoring of PDN or Shared PDN services if provided by an HCBS LVN.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver

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

Neither the Waiver Agency nor DHCS will authorize direct care services, or any combination of direct care and protective supervision services, exceeding 24 hours of care per day under this waiver, regardless of the funding source. Direct care services are defined in the "Additional Needed Information" section of this Waiver. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

When the direct care needs of a participant cannot be met by providing 24 hours of direct care services, the WA must contact DHCS to discuss potential resources to meet the needs of the participant to continue to protect their health and welfare.

This waiver service is only available to individuals age 21 and over. All medical necessity Private Duty Nursing services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Waiver Nurse Provider - RN
Agency	PDHC
Agency	HHA
Individual	HCBS Waiver Nurse Provider - LVN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by a HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Private Duty Nursing services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Private Duty Nursing services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:

Agency

Provider Type:

PDHC

Provider Qualifications

License *(specify):*

PDHC providers must be licensed and certified by the State of California and must meet the requirements specified in CCR, Title 22, Sections §51184, 51242, 51242.1, 51340.1 and 51532.3; Health and Safety Code, Sections §1760; and Welfare and Institutions Code, Section §14132.10.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

As a Waiver service provider, the PDHC will provide medical necessity nursing services to eligible HCBA Waiver participants who have turned 21 who wish to receive medical necessity private duty nursing within a PDHC licensed to operate a TCU. Private duty nursing services provided by a PDHC TCU to eligible individuals, do not include nursing services provided in a licensed health facility.

Legal Authority and Requirements

As a Waiver service provider, the PDHC shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

1. A PDHC shall be licensed in accordance with Health and Safety Code §1760.2, 1760.6, 1267.13 and 1337 and shall provide skilled nursing waiver services in accordance with CCR, Title 22, §51003 and 51344 and the waiver document. To the extent that the waiver provisions conflict with the Welfare and Institutions Code statutory and implementing regulatory provisions governing availability of PDHC services for individuals 22 and over, the waiver provisions and Health & Safety Code provisions allowing PDHC nursing services for individual 22 and over under specific circumstances shall prevail.

2. A PDHC must be enrolled as a Medi-Cal Waiver provider as required under state and federal Medicaid provider enrollment law, including but not limited to, 42 U.S.C. 1396a(78), 42 CFR Part 455, Subpart E, Welfare & Institutions Code, Division 1, Part 3, Chapter 7, Article1.3, and CCR, Title 22, Division 3, subdivision 1, Article 1. The PDHC must also sign a Waiver provider agreement.

3. Any subsequently adopted laws or regulations that exceed the PDHC waiver provider participation requirements shall supersede the PDHC waiver provider requirements and shall be applicable to all PDHC waiver providers.

The facility will be maintained in good repair and shall provide a safe, clean, and healthy environment at all times, and comport with physical plant requirements included in Health and Safety Code § 1760 - 1763.4. All persons shall be protected from hazards throughout the premises.

A PDHC Providing Waiver Services:

As a provider of Waiver private duty nursing services, a PDHC shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to Waiver participants shall meet all licensing requirements as specified in California Business and Professions Code and all the SOP of the HCBA Waiver. The primary category of service provided by a PDHC is nursing services, which must be available to Waiver participants consistent with their individual care needs.

The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.

Documentation:

The PDHC will assess each HCBA Waiver enrolled individual for needed or required services as identified by the individual, their legal representative/legally responsible adult(s), primary care physician, family, caregivers, and/or other individuals at the request of the individual, in accordance with the Waiver POT.

All Waiver private duty nursing services rendered by the PDHC TCU shall require prior authorization and reauthorization in accordance with CCR, Title 22, §51003, and the terms of the Waiver.

The PDHC shall prepare a TAR and submit it to the Waiver Agency, or DHCS in areas of the state not covered by a Waiver Agency, for each waiver participant seeking to utilize PDHC TCU private duty nursing services. The initial TAR submitted by the PDHC shall include a copy of the POT signed by the primary care physician as well as the PDHC’s current facility license. TARs submitted for

reauthorization shall be accompanied by an updated primary care physician signed POT and a renewed facility license, as appropriate.

Each PDHC shall maintain a medical record chart for each waiver participant. This medical record shall include documentation regarding all contact made with PDHC professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to the CMT or HCBA Case Management provider for any scheduled or unscheduled visit. All PDHC documentation shall be maintained in compliance with the applicable Federal and State laws, and HCBA Waiver Provider Standards of Participation. The PDHC shall also maintain records to document that the nursing staff requirements of these SOP have been met and have those records available for inspection or review by the Waiver Agency or DHCS upon request at any time.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with DHCS' Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

As a licensed PDHC private duty nursing service provider shall provide training regarding care appropriate for each waiver participant's diagnoses and their individual needs, to all facility staff. The supervisor(s) of licensed and unlicensed personnel will arrange for the training of their staff to be provided by the PDHC. Providing training to PDHC staff is a requirement to be enrolled as a Waiver provider and is not reimbursed by either Medi- Cal, the Waiver Agency, or the Waiver.

Each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed with the respective scope of practice. California Department of Public Health Licensing and Certification (L&C) staff PDHC L&C will determine if the PDHC will determine if the PDHC policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their primary care physician.

As determined by L&C, the PDHC is responsible for the orientation and training of all staff that render care. This includes the review of new and existing PDHC policies and procedures and training and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the PDHC.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code § 1725 et seq.; 22 CCR § 74600 et seq

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - LVN

Provider Qualifications

License *(specify):*

BPC, Div. 2, Chptr 6.5
CCR, Title 16, Div. 25, Chptr 1 CCR Title 22, §51069

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider--LVN” means a Licensed Vocational Nurse who provides HCBS Waiver LVN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver LVN services” means private duty nursing services, as described in the HCBA Waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by and HCBS Waiver LVN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and secure the health, safety, and well-being of the vulnerable HCBA Waiver population, a HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• LVNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver LVN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBA Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver LVN acting as a direct care provider
The initial HCBS Waiver LVN provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an LVN in the State of California. The LVN shall notify the Waiver Agency or DHCS in writing of any change in the status the LVN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

D. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience.

Annually the HCBS Waiver LVN provider shall submit the following documentation to the Waiver Agency or DHCS:

A. Evidence of renewal of BLS certification and unencumbered LVN licensure prior to expiration.

B. If services have been rendered within the last 12 calendar months, written evidence, in a format acceptable to the Waiver Agency or DHCS, of on-going education or training caring for the type of individual for whom services are being provided, at least once per calendar year.

C. If services have been rendered within the last 12 calendar months, a copy of the most recent POT that reflects the on-going CMT or HCB Case Management provider assessment and updated primary care physician orders. The POT shall be signed by the supervising RN, the waiver participant's current primary care physician, the waiver participant and the LVN, and shall contain the dates of service.

D. Evaluation of PDN services provided.

E. If services have been rendered within the last 12 calendar months, written evidence of ongoing contact with the supervising RN, CMT or HCBA Case Management provider and waiver participant's current primary care physician.

F. If private duty nursing is regularly scheduled, the HCBS Waiver LVN must notify the Waiver Agency or DHCS and the waiver participant or legal representative/legally responsible adult(s), in writing, at least thirty (30) days prior to the effective date of termination when the HCBS Waiver LVN intends to terminate HCBS LVN services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the waiver participant, as determined by the Waiver Agency or DHCS.

G. An HCBS Waiver LVN must provide Private Duty Nursing services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCBA Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

D. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience.

Annually the HCBS Waiver LVN provider shall submit the following documentation to the Waiver Agency or DHCS:

A. Evidence of renewal of BLS certification and unencumbered LVN licensure prior to expiration.

B. If services have been rendered within the last 12 calendar months, written evidence, in a format acceptable to the Waiver Agency or DHCS, of on-going education or training caring for the type of individual for whom services are being provided, at least once per calendar year.

C. If services have been rendered within the last 12 calendar months, a copy of the most recent POT that reflects the on-going CMT or HCB Case Management provider assessment and updated primary care physician orders. The POT shall be signed by the supervising RN, the waiver participant's current primary care physician, the waiver participant and the LVN, and shall contain the dates of service.

D. Evaluation of PDN services provided.

E. If services have been rendered within the last 12 calendar months, written evidence of ongoing contact with the supervising RN, CMT or HCBA Case Management provider and waiver participant's current primary care physician.

F. If private duty nursing is regularly scheduled, the HCBS Waiver LVN must notify the Waiver Agency or DHCS and the waiver participant or legal representative/legally responsible adult(s), in writing, at least thirty (30) days prior to the effective date of termination when the HCBS Waiver LVN intends to terminate HCBS LVN services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the waiver participant, as determined by the Waiver Agency or DHCS.

G. An HCBS Waiver LVN must provide Private Duty Nursing services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCBA Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Vocational Nursing and Psychiatric Technicians
DHCS and/or Waiver Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Case Management

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transitional Case Management (TCM) services are provided to transition a Medi-Cal waiver eligible individual from a health care facility to live and receive HCBS in a community setting of their choice. The Waiver Case Manager will have direct contact with the participant, legal representative/legally responsible adult(s), circle of support, and the participant's current primary care physician to obtain information that will allow the Waiver Case Manager to coordinate services such as housing, equipment, supplies, or transportation that may be necessary to leave a health care facility. TCM services may be provided up to 89 days prior to discharge from a health care facility. All TCM services provided will be billed against the waiver on the date of waiver enrollment.

TCM service will include an evaluation of the participant's medical and non-medical care needs, circle of support, home setting, and funding sources to support the participant's choice to transition from the facility to a home and community-based setting.

Requests for this service shall be accompanied by a POT that includes: the participant's medical necessity medical and non-medical care needs, and plan on how the individual's needs are met.

Prior to rending any services under the HCBA waiver, the provider must be enrolled as a Medi-Cal provider in compliance with state and federal law. Any services provided prior to the provider's enrollment as a Medi-Cal provider as required by state and federal law are not eligible for payment under the HCBA Waiver.

The participant may choose to receive Transitional Case Management either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Main. Optional Additional Needed Information.

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

TCM services may be provided up to 89 days prior to discharge from a health care facility. These services will be provided before the individual's enrollment in the waiver.

This service is only available when a Waiver Agency is not present.

This waiver service is only authorized for individuals age 21 and over. All medical necessity TCM for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Waiver Nurse Provider - RN
Agency	HHA

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
CCR Title 22, §51067;
CCR Title 16, Division 14

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBS Waiver Nurse Provider-RN” means a Registered Nurse who provides HCBS Waiver RN services, as defined below, and in this capacity is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

b. “HCBS Waiver RN services” means case management or private duty nursing services, as described in the HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in their home or place of residence by and HCBS Waiver RN, within their scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To protect and sustain the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCBS Waiver Nurse Provider application will not be processed should it be determined through official documentation that the Nurse’s professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State’s licensing agency; or that the Nurse has been subject to any disciplinary action or currently in or pending an investigation for, including but not limited to, the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

In areas where a Waiver Agency is not present, DHCS verifies that all providers meet waiver provider requirements at the point of provider enrollment and thereafter as necessary. DHCS staff shall periodically confirm that any provider of waiver services continues to meet the waiver program requirements through credentialing desk review and onsite provider visits.

In areas where a licensed provider is part of a Waiver Agency’s provider network, the Waiver Agency would annually verify the provider continues to meet waiver provider requirements through its credentialing process and onsite provider visits. DHCS will monitor the Waiver Agency and their provider network through annual Waiver Agency QAR.

An HCBS Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers. The Waiver Agency or DHCS may require additional documentation to support requests of this nature. Documentation required before the Waiver Agency or DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not selected or refused employment.

Qualifications of the HCBS Waiver RN
The initial HCBS Waiver Nurse Provider enrollment application shall be accompanied by all of the following documentation:

A. Current, unencumbered license to practice as an RN in the State of California. The RN shall notify the Waiver Agency or DHCS in writing of any change in the status the RN licensure within five (5) business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Transitional Case Management services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to the Waiver Agency or DHCS, of training or experience, which shall include at least one of the following:

a. A minimum of 1,000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

b. A minimum of 2,000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

c. A minimum of 2,000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.

d. A minimum of 2,000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals at one or more of the levels of care specified in this waiver.

D. An HCBS Waiver RN must provide Transitional Case Management services consistent with the participant's choice and interests, the participant's current primary care physician's orders, and the HCBA Waiver POT, within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

Health & Safety Code §1725 et seq.; 22 CCR §74600 et seq

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification
DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Anyone providing direct care to waiver participants in an ICF/DD-CN residence is subject to a criminal history and background check conducted by CDPH. All staff must be cleared prior to initiating contact with participants.

The providers must self-attest the verification of nursing licensure by the state Board of Registered Nurses (BRN). This action will include a review of any pending disciplinary action against potential staff.

The ICF/DD-CN residence RN staff must be licensed by the BRN. A criminal history and background check is required by the BRN in order to be issued a California RN license.

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

◉ **No. The state does not conduct abuse registry screening.**

○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Legally responsible individuals, including parents of minor children and spouses who meet Waiver SOP and are enrolled as an IHSS provider of personal care and/or paramedical services may receive payment to furnish WPCS and Paramedical Services under the Waiver when providing extraordinary care, and when all three of the following criteria are met:

1. The legally-responsible adult quit a full-time job or can't get a full-time job because they must care for the disabled participant, AND
2. If no other suitable care provider is available (willing and able), AND
3. If services are not received, the participant will be at risk of out-of-home placement or inadequate care.
4. Waiver Agencies, or DHCS in areas of the state not covered by a Waiver Agency, will verify the above criteria are met prior to identifying legally responsible individuals as care providers in the POT.

The needs of children under the age of 18 are assessed to determine the extraordinary care required by a disabled child, using age appropriate guidelines. WPCS and/or paramedical services are provided to Waiver participants to establish a safe environment in lieu of institutionalization. A child's needs for IHSS exist only to the extent that they are extraordinary for the age of the child regardless of the relationship of the custodian, the capabilities to provide care or presence at the time the care must be provided.

Domestic Services are not authorized for any minor or spouse, regardless of assessed needs, unless an exception is indicated.

To ensure payments made to legally responsible adults/legal guardians providing personal care to their spouse or minor child are only made for services that are rendered, a designee (i.e., not a dependent of the legally responsible adult) must be identified to sign timesheets.

Waiver Agencies, or DHCS in areas of the state not covered by a Waiver Agency, will also follow up with the participant, legal representative, and/or circle of support on a monthly basis to prevent fraud and/or conflicts of interest.

☒ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify

state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

Under certain, very limited circumstances, a parent, stepparent, foster parent of a participant, a spouse or legal guardian of a waiver participant, hereto referred to as legal representative/legally responsible adult, may provide select HCBA Waiver services that require a licensed professional provider.

The participant must have been assessed by either a Waiver Agency or DHCS. Services must be ordered by the participant's current primary care physician and authorized by the Waiver Agency or DHCS prior to waiver services being furnished.

A Waiver Agency or DHCS will authorize the participant's legal representative/legally responsible adult to provide HCBA Waiver services upon evidence the legal representative/legally responsible adult:

1. The relative or legal guardian must have an active Medi-Cal provider number with an HCBS category of service indicator;

2. Meets State licensing and/or certification requirements;

3. Meets the HCBA provider standards described in Appendix C-4;

4. Meets the HCBA Waiver SOP; and

5. Provides evidence of the inability to select a local licensed professional who meets the service requirements in the participant's POT, and attaches that written evidence to every TAR re-authorization request for licensed services.

The evidence of inability to select a local licensed professional must document that:

1. There are no willing or qualified providers;

2. A Waiver Agency is not present;

3. The participant lives in a remote or rural area experiencing shortages of licensed professionals;

4. Attempts were made to enlist and retain a qualified provider, such as the posting of classified advertisements, or contacting home health agencies or professional corporations; and

5. There is an accounting of interviews with potential providers including the reasons the provider was not selected or refused to provide the waiver service(s).

Legal representatives/legally responsible adults who meet the Medi-Cal and HCBA Waiver provider standards may provide the following HCBA Waiver services after they have been enrolled as a provider:

• Case Management, in areas of the State without a Waiver Agency;
• Community Transition Services;
• Environmental Accessibility Adaptations;
• Family/Caregiver Training;
• Private Duty Nursing;
• Habilitation Services;
• Home Respite;
• PERS Installation and Testing;
• PERS;
• Transitional Case Management, in areas of the State without a Waiver Agency; and
• Medical Equipment Operating Expense.

The Waiver Agency or DHCS will notify the waiver participant and/or legal representative/legally responsible adult of the decision to approve or deny the legal representative/legally responsible adult's request to provide waiver services by either authorizing the requested service(s) or issuing a NOA.

The participant must go through the entire application process to be eligible to enroll in the waiver. The CMT or

DHCS must make a LOC assessment visit in-person. Services must then be ordered by the participant's current primary care physician and authorized by the Waiver Agency and DHCS prior to the furnishing of waiver services. The provider must enroll and be approved as a Medi-Cal provider and meet all the standards of participation for their approved provider type. The Waiver Agency or DHCS is required to make annual home visits, to document that all services are being received as ordered on the POT. The provider is only allowed to bill for the specific authorized services. Monitoring and oversight reports are run on a monthly basis to verify that only claims for the amount of authorized waiver services are being paid.

Case management services provided by an RN Independent Nurse Provider in areas of the state not covered by a Waiver Agency, do not entail hands on services. Case management services includes planning and assisting the participant to access services, evaluating and assessing the participant's needs, filling out the proper paperwork, and submitting claims. DHCS is still required to make annual home visits to document that all services are being received as ordered on the POT and the participant's health and safety needs are all being met.

○ **Other policy.**

Specify:

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

Continuous and open enrollment is afforded to any willing and qualified provider who meets Medi-Cal and HCBA Waiver provider qualifications. Licensed providers must demonstrate they meet applicable state licensure requirements. Non-licensed providers must demonstrate they have the necessary skills to provide services as described on the POT. Information on how interested providers can become an HCBA Waiver provider is available online at the Medi-Cal website under Services, then Long-Term Care Alternatives. Provider enrollment information is also available in the Medi-Cal Provider Manual, provided at statewide DHCS presentations, and available on request by calling the DHCS Sacramento or Los Angeles office or calling the local Waiver Agency. The HCBA Waiver SOP are included in this waiver application.

In areas where a Waiver Agency is present, the Waiver Agency is responsible for ensuring all willing and qualified providers are enrolled in Medi-Cal and in good standing. In areas where a Waiver Agency is not present, DHCS enrolls all willing and qualified providers through the execution of the Medi-Cal Provider Agreement.

In areas where a Waiver Agency is not available, DHCS has developed a provider information packet for licensed providers that will include:

• HCBA Waiver Standards of Participation;
• Medi-Cal Provider Application forms and instructions;
• Forms and instructions for requesting authorization to provide HCBA Waiver services;
• Forms and instructions for submitting claims for payment of approved HCBA Waiver services that have been rendered; and
• Information on who to contact for questions or problems.

Providers, in areas where a Waiver Agency is not present, first must apply for and receive a National Provider Identifier (NPI) number to include on the Medi-Cal Provider Application forms. When that number is received the provider is instructed to return the completed provider application to DHCS. DHCS reviews the application to determine if the provider meets the waiver's SOP and Medi-Cal provider requirements. Upon approval, DHCS provides a category of service code that allows them to render and be reimbursed for HCBA Waiver services.

Under the contract with DHCS, Waiver Agencies must establish and implement policies and procedures for assuring that all willing and qualified providers have the opportunity to contract as waiver service providers. Waiver Agencies must subcontract with a sufficient number of service providers to allow participant choice of providers for each service, when possible, and with other qualified providers desired by the participant. In compliance with §1902(a)(23) of the Social Security Act, waiver participants are given the choice of any qualified provider who agrees to furnish the services.

DHCS monitors this requirement during the Waiver Agency QARs and Waiver Agency submission of subcontract information in quarterly progress reports.

Under the contract with DHCS, Waiver Agencies must recruit service providers on an ongoing basis. DHCS staff reviews and discusses provider recruitment efforts with Waiver Agencies during their annual QAR.

Annually, Waiver Agencies verify the subcontracted provider of waiver services continues to meet waiver provider requirements through onsite provider visits. DHCS verifies non-licensed providers continue to meet waiver provider requirements at the point of provider enrollment and as necessary through the Case Management Information Payrolling System (CMIPS).

In areas where a Waiver Agency is not present, annually, DHCS verifies that the provider of waiver services continues to meet the waiver program requirements through onsite provider visits and/or electronic records review. DHCS verifies non-licensed providers continue to meet waiver provider requirements at the point of provider enrollment and as necessary through MedCompass.

In areas where there is a Waiver Agency, providers are not required to contract with the Waiver Agency. They may provide authorized services as long as they are determined to be enrolled in Medi-Cal and a qualified waiver provider based on the provider qualifications outlined in the waiver application. Waiver Agencies are responsible for prior authorization of all HCBA Waiver services and verification that the requested services are in accordance with the participant's current POT and are medical necessity.

In areas where there is no Waiver Agency, DHCS is responsible for prior authorization of all HCBA Waiver services and verification that the requested services are in accordance with the participant's current POT and are medical necessity. HCBA Waiver providers are responsible for direct submission of claims to the FI.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory 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 authorized HCBA Waiver case files for which the required licensure and/or certifications were obtained, as required for each provider type in Appendix C-3 of the Waiver, prior to services being furnished by the provider. Numerator: Number of case files with required licensure and/or certifications / Denominator: Total number of case files reviewed.

Data Source (Select one):
Record reviews, on-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%
☒ **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:

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

For each performance measure the State will use to assess compliance with the statutory 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 non-licensed/non-certified individuals with current signed provider agreements within 24 months, indicating an understanding of the need to provide care in accordance with waiver requirements and the participant's current POT.
Numerator: Number of participants with non-licensed/non-certified providers with current signed provider agreements / Denominator: Number of files reviewed

Data Source (Select one):
Record reviews, on-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:

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

For each performance measure the State will use to assess compliance with the statutory 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 HCBA Waiver Agencies with documentation of training that was conducted in accordance with state requirements and the approved waiver, within the last 12 months. Numerator: Number of HCBA Waiver Agencies with documentation of training that was conducted in accordance with state requirements and the approved waiver, within the last 12 months / Denominator: Number of HCBA Waiver Agencies

Data Source (Select one):
Record reviews, on-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**

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

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.

DHCS assures that the waiver services delivered to HCBA Waiver participants are provided by qualified waiver providers. DHCS requires that all providers meet HCBA Waiver Standards of Participation for each provider type, sign a Waiver Provider Agreement, and meet any California licensing and certification requirements prior to providing services to waiver participants. Documentation of current licenses and training are maintained at the Waiver Agency offices.

Provider performance is monitored by the Waiver Agency on an annual basis. Should deficiencies be reported to DHCS or discovered during the annual provider visit and/or review of electronic case files, the Waiver Agency must create an Event/Issue Report with a plan of corrective action. The Event/Issue Report would include a description of the deficiencies/issues found, the plan to address/resolve the deficiency/issues and the resolution of the deficiency/issues. All Event/Issue Reports are monitored and reviewed by DHCS until a resolution has been documented. In the event serious issues are found that would have a negative impact on the health or wellbeing of a waiver participant the issue would require the Waiver Agency to report the issue to the appropriate local or State agencies such as Adult Protective Services (APS), Child Protective Services (CPS), local law enforcement, or the CDPH Licensing and Certification, as well as DHCS.

DHCS uses the QAR to aggregate data gathered during the annual Provider Record Review to analyze statewide trends and provide problem resolution with technical assistance and training to the Waiver Agency, when necessary.

Within 30 days of the Provider Record Review, DHCS will present an analysis of the findings to the Waiver Agency. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the Waiver Agency. DHCS will follow up on the effectiveness of any remedial action within 30 days. Remedial actions will be re-evaluated at the next QAR.

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:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

For information regarding the HCBS Settings Statewide Transition Plan applicable to the HCBA Waiver, please refer to Attachment #2 in this application.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Treatment (POT)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☒ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☒ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The CMT, or other case management entity in areas of the State without a Waiver Agency, provides the waiver participant, legal representative/legally responsible adult(s), and/or circle of support (et al.) with information on the purpose of the POT and information on local non-Medi-Cal, Medi-Cal State Plan, and Medi-Cal Waiver services that are available in the community. The CMT/case management entity encourages the participant to include individuals to support them when identifying their goals, needs, preferred services and providers in the development of their home program. Participants are encouraged to select providers best suited to meet their needs, taking into account the providers' experience providing direct care services in the home, their availability, hours of service, and cultural and linguistic competencies. The POT must be signed by the participant's current primary care physician who is attesting to the medical necessity of the waiver services identified in the POT.

Eligible beneficiaries are also provided an Informing Notice when they have been determined to be eligible for enrollment into the Waiver to let them know they have the option to receive services at home or in the community as an alternative to receiving care in an institution. The Informing Notice describes the goal of the Waiver and the roles and responsibilities of the participant, legal representative/legally responsible adult(s), the primary care physician, the CMT and Waiver Agency, and DHCS.

Pursuant to 42 CFR 441.730(b), individuals or entities that evaluate eligibility or conduct the independent evaluation of eligibility for state plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan cannot:
- Be related by blood or marriage to the individual or to any paid caregiver of the individual;
- Be financially responsible for the individual;
- Be empowered to make financial or health related decisions for the individual; or
- Have a financial interest in any entity paid to provide care to the individual

Pursuant to 42 CFR 431.301(c)(1)(vi), case management must be separate from service delivery functions. A conflict occurs not just if the case management provider is also a service provider, but when the case management provider has an interest in a provider or is employed by a provider. If a Waiver Agency, or other case management provider, also provides direct services without first obtaining written approval from DHCS, they are in violation of this rule and may be subject to sanctions, including but not limited to the required repayment to DHCS in the amount of all compensation received for providing the waiver services and the comprehensive care management during that time.

If and when the Waiver Agency, or other case management provider, responsible for service plan development seeks approval to provide direct services, they must:
- Demonstrate to DHCS, and provide supporting evidence, that they are the only willing and qualified case management and direct service provider available;
- Provide full disclosure to participants/families, and assure they are supported in exercising their right of free choice in providers; and
- Demonstrate that they have implemented safeguards to separate case management and service provision (different staff).

If DHCS determines that a Waiver Agency or other case management provider that was granted approval to provide waiver services is not complying with the above requirements, or if a conflict of interest issue has arisen, DHCS has the authority to revoke the permission to provide direct services.

If authorized to provide case management and direct care, Waiver Agencies must also:
1. Provide a disclosure form to participants/families to sign that includes:
- Full disclosure and assurances that participants/families are supported in exercising their right of free choice between providers, when available;
- Description of the individual dispute resolution process;
- Full disclosure that only one willing and qualified provider is available to provide case management and direct services in the participant's county of residence;
- Assurance that the Waiver Agency will separate case management and the provision of direct care (different staff with different lines of supervision);
- Assurance that the Waiver Agency providing case management and direct services does so only with the approval of the State; and
- Notice that the State will provide direct oversight and periodic evaluation of the established safeguards.

2. Develop policies and procedures, and set up internal firewalls to restrict access to case notes.
3. Submit to DHCS a formal agreement, to maintain a separation between waiver case management and direct services functions and lines of supervision, signed by the program Administrator.
4. Require employees providing case management and direct services to sign DHCS-approved agreements acknowledging their understanding of, and willingness to, comply with mandated separation of case management and direct service functions.
5. Ensure no direct services are provided to Waiver participants by Waiver Agency staff or affiliates until receiving written approval from DHCS.

DHCS will directly oversee and periodically evaluate the safeguards put in place by the Waiver Agency or other case management entity to verify ongoing compliance.

After receiving approval from DHCS to provide direct care services, Waiver Agencies must continue to search for willing and qualified HCBS providers of direct care service(s). Documentation of ongoing recruitment efforts must be included in the participant's POT and case notes, and must be attached to each direct care TAR submitted to DHCS for approval. Waiver Agencies may not authorize direct care TAR for their own staff or affiliated businesses.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Waiver Services – Plan of Care for the developmentally disabled individual choosing waiver services in an ICF/DD-CN as the residential facility:

1. Individual Program Plan (Regional Center)

The Regional Centers use a planning process call an IPP. For children age 0 to 36 months old, this process is called the IFSP. The IPP/IFSP is developed through a process of individualized needs determination, and is prepared jointly by the planning team. The planning team consists of the individual with developmental disabilities or the parents of a minor and, where appropriate, the participant's legal guardian or conservator, or authorized representative, and an authorized Regional Center representative, and anyone the individual invites to participant.

The IPP/IFSP lists goals and the preferred services that will be utilized to reach those goals. It lists who will provide the service and who will pay for it. All services listed in the IPP/IFSP will be provided either by a generic or natural resource, a Regional Center vendor (a business approved by the Regional Center) or by Regional Center staff.

2. ISP – ICF/DD-CN

Regulations in Title 22, CCR, §76860, state in part that an ISP is a plan developed for each individual participant by the residence's interdisciplinary professional staff/team, and will include the following information:

A. Implements the prescriptive requirements of the Regional Center's IPP/IFSP.
B. Is based on assessment data pursuant to Title 22, CCR, §76859 and is completed within 30 days following admission.
C. Is developed by the residence's interdisciplinary professional staff/team, and includes participation of the waiver participant, direct care staff, and relevant staff of other agencies involved in serving the participant. Prior to development of the ISP, the participant's parents, if the participant is a minor, or the participant's authorized representative are invited to attend the service plan conference.
D. Identifies the participant's developmental, social, behavioral, recreational, and physical needs and strengths.
E. Includes established prioritized objectives, written in behavioral and/or developmental terms that are measureable and time limited, for meeting the participant's identified needs and goals.
F. Identifies the method and frequency of evaluation.
G. Includes a daily program schedule that specifies the time and duration of all ADLs; and time, duration, and location of all specified programs.
H. Specifies the persons and agencies responsible for implementing and coordinating the service plan.
I. Contains monthly progress notes related to the service plan, goals and objectives.
J. Includes the anticipated date of discharge, plans for services, and includes the specific agencies or persons responsible for follow-up services in the participant's new environment.

3. Individual Plan of Care – Medical and Nursing Staff or Health Care Professional

Regulations in Title 22, CCR, §73311, state in part that nursing services shall include, but not be limited to, the following:

A. Identification of problems and development of an Individual POT for each participant based upon initial and continuing assessment of the participant's needs by the nursing staff and other health care professionals. The POT shall be reviewed and revised as needed but not less often than quarterly.
B. Assurance that the attending physician will be notified immediately if/when a participant exhibits unusual signs or behavior.
C. Ensuring that participants are served the diets as prescribed by attending physicians, and that participants are provided with the necessary and acceptable equipment for eating, and that prompt assistance in eating is given when needed.
D. Any marked or sudden change in weight shall be reported promptly to the attending physician.

Plan of Treatment (POT)

Beginning with the application for waiver services and throughout the development of the POT, the CMT or other case management provider makes sure that they participant is provided with the opportunity, and is encouraged, to involve individuals of their choice in the development of the POT. The Informing Notice informs the waiver participant, and/or legal representative/legally responsible adult of the participant's authority determining who can assist them in selecting

and identifying waiver services and providers. The Informing Notice includes a complete description of the roles and responsibilities of the waiver participant, primary caregivers, the participant's current primary care physician, HCBA Waiver service providers, and the Waiver Agency, in the development and implementation of the POT, as applicable.

The CMT provides the waiver participant, legal representative/legally responsible adult(s), and/or circle of support with information on the purpose of the POT and encourages them to participate in identifying the participant's goals, needs, medical necessity Waiver services, and providers to support and maintain the safety through the implementation of the home program. The CMT also provides person-centered comprehensive care management at the request of the waiver participant, legal representative/legally responsible adult(s), and/or circle of support. The information is provided verbally at the initial and ongoing face-to-face home visits well as in writing in the HCBA Informing Notice. During the ongoing home visits, the CMT reviews the POT with the waiver participant, legal representative/legally responsible adult(s), and/or circle of support to verify the POT accurately reflects the participant's medical necessity care needs, type and duration of services, and providers of the service. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services identified in the POT.

The CMT is available to assist the waiver participant, legal representative/legally responsible adult(s), and/or circle of support with information on local non-Medi-Cal, State Plan, and waiver services that can meet the participant's identified needs. Participants are encouraged to select waiver providers that are best suited to meet their needs, taking into account experience providing direct care services in the home, availability, hours of service, and cultural and linguistic competencies.

In areas of the state without a Waiver Agency, DHCS informs case management providers who assist the waiver participant in the development of the POT, of the requirement to include the waiver participant, legal representative/legally responsible adult(s), and/or circle of support in the development of the POT. The provider receives this information verbally during the waiver participant's initial assessment, in the HCBA Informing Notice that is mailed to the HCBA Waiver provider, and during the annual provider visit.

Participants served under the HCBA Waiver need to have at least one identified back-up caregiver who is trained in the care of the participant in the event the provider of direct care services is not available for the total number of hours approved by the Waiver Agency or DHCS. The CMT will assist the participant and/or legal representative/legally responsible adult in identifying a back-up caregiver. Back-up caregivers may consist of community-based organizations, family members, home health agencies, licensed foster parent(s) or any other individual that is part of the participant's circle of support.

The identified back-up caregiver will be included in the POT. The POT must be signed by the participant's current primary care physician, designated physician assistant or nurse practitioner (herein referred to as "participant's current primary care physician"). For purposes of the HCBA Waiver, the participant's current primary care physician is the physician that oversees the participant's home program and determines the medical necessity of the listed waiver services. In order for a back-up caregiver to be paid, they must be enrolled as a waiver provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The CMT or other case management provider is responsible for working with the participant, legal representative/legally responsible adult(s), and/or circle of support to develop the POT. DHCS policies and procedures require the CMT or other case management provider to ask the applicant/participant and/or legal representative/legally responsible adult(s), if there is anyone they would like to include when identifying and speaking about their goals, care needs, medical necessity Waiver services, and providers, in the development of the POT; this may include, but is not limited to members of their circle of support.

When the CMT meets face-to-face with the applicant/participant the RN conducts a comprehensive clinical assessment to determine the applicant/participant's functional need(s) and level of care. During the same visit the social worker, et al. discusses and documents the applicant/participant's strengths, capacities, preferences, and desired outcomes. The CMT also presents the MOHS to the participant, legal representative/legally responsible adult(s), and circle of support when possible, and explains each of the available options. The MOHS is a planning instrument the CMT or other case manager utilizes to help participants make informed choices about the services and providers available to meet their preference(s) and need(s). Note: All references to the participant includes the role of their legal representative, if applicable.

After the CMT has met face-to-face, with the participant, legal representative/legally responsible adult(s), and circle of support to discuss the participant's preferences, goals, and desired outcomes, the CMT is responsible for developing a comprehensive POT. Once developed, the CMT meets with the participant and circle of support to review the POT, make participant-directed changes (if requested), and provide the participant with a list of resources and service providers from which to choose when they schedule the selected services.

The CMT then sends the POT to the participant's primary care physician for final review and signature. Once signed by the participant's physician, the CMT, participant, and/or the delegated representative(s) contact providers to schedule services included in the approved POT. The CMT continues to support the participant during the provider selection/scheduling process, and continues the update the POT based on the participants preference(s) and need(s).

Some of the services included in the POT are managed by the participant with help from their circle of support and the CMT. For example, eligible participants who choose in-home supportive services (IHSS) hire their own personal care providers. The CMT monitors the timeliness of the WPCS only POT.

The CMT is responsible for completing the initial POT and updating it at least every six months, or more frequently when needed. If after the completion of the initial POT it is determined that the POT does not meet the participant's needs due to significant changes in the participant's condition, the CMT, consulting with the waiver participant's current primary care physician, must update and submit the updated POT to the current primary care physician for signature. "Significant changes" are changes that suggest the need to modify the POT, such as changes in the participant's health status, home setting, or availability of waiver providers.

In areas of the state not covered by a Waiver Agency, if the waiver participant's only service is WPCS then the waiver participant, legal representative/legally responsible adult(s), and circle of support are responsible for developing the POT with the assistance of DHCS. Waiver service providers are required to submit a copy of the waiver participant's current primary care physician-signed POT with each request for authorization of WPCS services.

The CMT or other case management provider must use the Integrated Systems of Care's POT. The POT must include the participant's demographic information; treating and current primary care physician information; medical information and diagnosis; LOC; all required Waiver services, including amount, frequency, duration and Waiver service provider type; Medi-Cal State Plan services; prescribed durable medical equipment; medication plan; nutritional requirements; the treatment plan for the home program; the participant's functional limitations; permitted activities; mental status; medical supplies; ongoing therapies and therapy referrals; treatment goals, including rehabilitation potential; and training needs for the participant and family, and an emergency backup plan. The CMT completes the POT summarizing the health and functional status of the waiver participant during the previous POT period and the effectiveness of the services provided.

The CMT reviews/assesses the provision of services included in the POT during the monthly case management calls or visits; during the reevaluation of the participant's LOC; at the annual provider visit; and with each request for waiver services. Any necessary or suggested revisions of the POT because of changes in the participant's health status, home setting, or availability of waiver providers, are discussed with the participant and/or legal representative/legally responsible adult(s) and/or circle of support, the participant's current primary care physician, and waiver service providers. Modifications to the POT are made only with approval of the participant, legal representative/legally

responsible adult and the participant's current primary care physician.

Waiver Services – Plan of Care for the developmentally disabled individual choosing waiver services in an ICF/DD-CN residential facility:

For purposes of the developmentally disabled individual choosing to receive waiver services in an ICF/DD-CN residential facility, statutory requirements are met using the IPP developed by the Regional Center, or for children under 36 months, the IFSP; the ISP developed by the ICF/DD-CN if services are to be rendered at the residential facility; and the medical POT developed by the participant's case manager. This process will be referred to as the "plan of care." The plan of care is the fundamental tool by which the State will maintain the health and welfare of developmentally disabled participants receiving waiver services. As such, the plan of care will be subject to periodic review by DHCS. DHCS reviews the plans of care during their onsite monitoring reviews at least every 12 months, or more often if unannounced visits or extra onsite visits are needed. DDS Regional Centers review the IPPs every three months or when there is a significant change. These reviews will determine the appropriateness and adequacy of the waiver services and will confirm that the services are consistent with the nature and severity of the participant's disability, as well as medical and nursing needs. FFP will not be claimed for State Plan services that are not included in the plan of care.

DD/CNC residents have 3 separate service plans:

1. The Individual Program Plan (IPP-Regional Center)
2. The Individual Service Plan (ISP-ICF/DD/CN), and
3. Individual Plan of Care (Medical and Nursing Staff or Health Care Professional)

All are described in D-1-c: and are completed and utilized to provide the appropriate services to the DD/CNC waiver participant.

HCBA Waiver Agencies are contractually bound to adhering to principles of person-centered planning, which includes meeting with participants at times and locations of the participant's choice.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The POT documents the CMT's nursing evaluation and proposed interventions enabling the participant to live safely at home in the community. The CMT reviews the POT, taking into account the participant's medical condition and medical necessity care need(s), and signs and verifies the POT is signed by the service provider(s) and the participant's current primary care physician. The participant's current primary care physician's signature is evidence that they have reviewed the POT, agree that it addresses all of the participant's medical necessity health care needs so that they can live safely at home or in the community.

The POT is developed based on information obtained from the nursing evaluation and the home safety evaluation. The latter demonstrates that the participant's home environment is safe and conducive to the successful implementation of a home and community-based services program. It includes an evaluation of risk factors affecting the participant's health and safety (e.g. sufficient care providers trained in the participant's care needs, effective backup plan, and evaluation regarding the potential for abuse, neglect and exploitation). Identified conditions that may affect the participant's health, welfare, and/or safety require the CMT to develop a plan of correction and provide evidence that the conditions are corrected.

An approved POT will include the following information:

• Assurance that the area where the participant will be cared for can accommodate the use, maintenance, and cleaning of all medical devices, equipment, and storage supplies necessary to maintain the participant in the home in comfort and safety, and to facilitate the nursing care required;
• Assurance that primary and backup utility, communication, and fire safety systems and devices are available, installed, and in working order, including grounded electrical outlets, smoke detectors, fire extinguisher, and telephone services;
• Evidence that local emergency and rescue services and utility services have been notified that a person with special needs resides in the home;
• Assurance that all medical equipment, supplies, primary and backup systems, and other services and supports, are in place and available in working order, or have been ordered and will be in place at the time the participant is placed in the home;
• Documentation that the participant is not subjected to abuse, neglect, or exploitation and is knowledgeable of their rights and who to contact if incidents occur; and
• Documentation that the caregivers are knowledgeable of the care needs of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants receiving services through the HCBA Waiver can select any provider who is enrolled ad a Medi-Cal provider and willing to provide State Plan or Waiver services. In areas where there is a Waiver Agency, qualified and willing providers must sign an HCBA Waiver provider agreement that is submitted to the Waiver Agency, they do not, however, have to enter into a contract with the Waiver Agency. In areas where there is no Waiver Agency, DHCS will enroll all willing and qualified providers. Payment for all qualified and willing providers will be made through the FI. The CMT provides the participant, legal representative/legally responsible adult(s), and/or members of his/her circle of support with a list of current HCBA Waiver providers and information on how a non-HCBA Waiver provider can become a Waiver provider.

Waiver participants are encouraged to identify providers of waiver services who can best meet their medical necessity needs. Factors considered should include a provider's experience, abilities, and availability to provide services in a home and community-based setting, as well as the ability to work with the CMT, the participant's other caregivers, and the participant's current primary care physician. When requested by the participant and/or legal representative/legally responsible adults, the CMT can assist the participant and/or legal representative/legally responsible adults in identifying and waiver service providers.

For potentially eligible Waiver applicants living in a long-term care facility, the initial contact with the potential participant (and representatives) includes a discussion of the options for settings in which they can reside. The participant is presented with the options available with a discussion of the similarities and distinctions between the setting types. CMTs are required to provide information, both oral and written, to provide participants with the information they require to make an informed choice.

Licensed providers must demonstrate they meet applicable state licensure requirements. Non-licensed providers must demonstrate they have the necessary skills to provide services as described on the POT. Information on how interested providers can become an HCBA's Waiver provider is available online at the Medi-Cal website, "Providers & Partners" page.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The DHCS MC is responsible for approving the initial POT, which must be signed and submitted to DHCS by the CMT in areas of the state covered by a Waiver Agency, at the time of requested waiver enrollment. POTs not meeting the HCBA Waiver standards shall be adjudicated by a second level review before they are returned to the CMT with instructions regarding needed revisions or additional information. In these instances, the CMT meets with the participant, legal representative/legally responsible adult(s), and members of the circle of support to make the required revisions to the POT. The revised POT must be sent back to the participant's current primary care physician for review and signature prior to resubmission to the DHCS MC. The revised POT should accurately reflect the participant's medical necessity health care needs, goals, preferred services, and providers prior to enrollment in the HCBA Waiver, or approval for requested waiver services. After DHCS approval of initial waiver enrollment, the CMT continues to review and update the POT with the participant, legal representative/legally responsible adult(s), and/or circle of support, during each home visit, and with the HCBA Waiver providers during the annual visit, or live video conferencing meeting.

DHCS reviews all initial POTs upon receipt of a completed application and request to enroll into the Waiver. If DHCS does not agree with the POT, a second level review will be performed by DHCS. DHCS reviews a statistically valid sample size of all redeterminations received. DHCS also reviews a statistically valid sample size of both initial and redeterminations during the annual QAR.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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

and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

Waiver Agency - DHCS requires the Waiver Agencies and all other HCBA Waiver providers to maintain waiver participant case documentation and records that support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

In areas of the state covered by a Waiver Agency, the CMT is responsible for coordinating, implementing, and updating the implementation of the POT to verify that it accurately reflects the participant's care needs and that the participant is receiving the authorized waiver services. The CMT monitors to determine if waiver services are furnished in accordance with the POT by maintaining regular contact with the participant, legal representative/legally responsible adult(s), and circle of support, and takes action as necessary, to resolve any issues. Contact includes home visits and telephone calls. The CMT is responsible for apprising DHCS and the MC of the participant's status and reporting any unforeseen issues or problems that could negatively affect the participant.

The Waiver Agency is responsible for Service Plan monitoring and maintaining participant case notes documenting the participant's health status and identified problems and issues. The Waiver Agency is responsible for documenting plans of correction and resolution of identified issues regarding implementation of the participant's POT or their health and welfare. The Waiver Agency's program manager/case management supervisor frequently reviews the CMT's case notes and documentation to verify that any plan of correction was completed with appropriate follow-up. During regularly scheduled meetings with the participant and/or their legal representative/legally responsible adult(s) and/or circle of support, the CMT asks if the participant is satisfied with the plan of correction and resolution.

At the home visit, the CMT reviews the POT with the participant and/or legal representative/legally responsible adult(s), and members of their circle of support to:
• Verify the participant's POT is current and signed by the participant, legal representative/legally responsible adult(s), and the participant's current primary care physician. Copies of the current and past POTs are filed in the participant's case record.
• Verify the participant is receiving the services described in the POT, review the POT with the participant, legal representative/legally responsible adult(s), and members of their circle of support and discuss the recommendations for waiver and non-waiver services and providers of services.
• Adjust the POT to meet the participant's medical necessity health care needs and personal goals. During the on-site home visit the CMT assesses if the participant is receiving all the services identified in the POT, whether the participant is satisfied with the care being delivered, and if the participant is receiving the services needed to remain safely at home.
• Prepare a complete and accurate written medical record, including diagnoses, complete evaluation, treatment plan, and prognosis that is available when determining the medical necessity for the waiver services described in the POT.
• Review and update the backup plan to be followed in the event a provider is not available. The CMT will assist the participant, legal representative/legally responsible adult(s), and members of their circle of support in identifying providers and community resources as part of their backup plan.
  o If a participant does not have friends, family, or a circle of support able and willing to provide unpaid back up care in the event a paid provider does not arrive to provide care, the CMT must work with the participant to identify two back up plans to maintain the participant's safety.
• Document that the participant and legal representative/legally responsible adult(s) are instructed and understand how to recognize and report abuse, neglect and exploitation. The POT must also identify any risk for abuse, neglect and exploitation and how incidents will be prevented.
• Prepare the written home safety evaluation is complete and addresses all identified issues in the POT. The CMT must assess the safety of the participant's community-based home by evaluating participant accessibility, structural barriers, utilities, evacuation plans, and communication and fire safety systems and devices.
• Help the participant, legal representative/legally responsible adult(s) address issues identified during the home safety evaluation; and once remediated, document the participant's home is safe.

The CMT will discuss each of the problems or deficiencies identified in the POT with the participant, her legal representative/legally responsible adult(s), and members of the circle of support. All safety issues must be resolved and documented in the POT, and then reviewed and approved by the participant's current primary care physician, before additional waiver services and/or continued enrollment in the HCBA Waiver will be authorized. Health and safety issues are documented using the Event/Issue Report, documented in the POT, and included in the participant's case record.

Upon enrollment into the HCBA Waiver, the CMT reviews the initial POT with the participant, legal representative/legally responsible adult(s), and circle of support a second time. Ninety (90) days after DHCS approval for participant enrollment and the participant begins receiving waiver services, the CMT conducts a home visit to assess how the participant is coping. The CMT reviews the POT with the participant, legal representative/legally responsible adult(s), and circle of support to verify that services are provided as described. Subsequent scheduled LOC reevaluation visits include a review of the POT with the participant, legal representative/legally responsible adult(s), and circle of support to determine if the POT continues to meet the participant's medical necessity health care needs.

The level of case management acuity system is used to determine the frequency of CMT home visits based upon the participant's risk factors and the complexity of the home program. The system identifies four levels of case management of increasing acuity. The level of acuity is reevaluated at each home visit and upon changes to the participant's medical care needs, support system, and provider types. The level of case management acuity system is described in detail in Appendix B, at item B-6(g).

Between the scheduled home visits, the CMT maintains regular contact with the participant. A record of the interim contact is documented in the case notes section of the participant's case file. Based on interim contact reports and/or information received from the participant, the CMT must update the POT to reflect changes in the participant's medical necessity health care needs, waiver providers, and/or the delivery of waiver services.

Waiver Agencies shall take all reasonable steps to locate a sufficient number of service providers to furnish participant choice of providers for each service, when possible. Waiver participants may choose any qualified provider who agrees to furnish waiver services. The Waiver Agencies must offer to subcontract with qualified Waiver providers, but a qualified Waiver provider is not required to subcontract with the Waiver Agency in order to provide HCBA Waiver services. DHCS monitors whether the Waiver Agency is taking all reasonable steps to locate a sufficient number of service providers through the annual QAR's, and random case file audits within DHCS' MedCompass case file management system, to which Waiver Agencies are responsible for uploading all of their provider and subcontracted providers information for verification and tracking purposes.

DHCS monitors the number of providers a Waiver Agency has within their network and requires that they continue to take all reasonable steps to continually locate new willing and qualified Medi-Cal providers to expand their provider network. The Waiver Agency shall maintain documentation received from all providers requesting to become a service provider for DHCS' review during the annual QAR. The Waiver Agency shall provide participants with a directory of available providers within their network (i.e., of those from whom they have received an HCBA Waiver provider agreement), and inform participants that they may choose a provider that is not in the Waiver Agency's network to provide Waiver services, as long as the provider is enrolled with Medi-Cal. The Waiver Agency shall maintain a record in the case file showing that they have informed the participant of their options, and DHCS will review the case files during the annual audit.

DHCS will monitor the Waiver Agency's performance through annual QAR. When corrective action is required, the Waiver Agency shall provide DHCS with a formal CAP to address any deficiencies, and modify the CAP as necessary to comply with the identified requirements until the CAP is determined to be acceptable by DHCS. DHCS may, at its discretion, conduct follow-up visits and/or electronic records review to evaluate the effectiveness of the Waiver Agency's CAP implementation. DHCS provides ongoing technical assistance to Waiver Agencies and requires quarterly reports from each Waiver Agency that includes updates on quality assurance activities, incident reports, etc.

DHCS analyzes case records, progress notes, care management activities, assessment/reassessments, the Waiver Participant's plan of care, individual service plans, service authorization, special incidents and/or critical events, complaints lodged by Waiver participants, their family/legal representatives or others against providers, provider qualifications, subcontracts, financial statements or audits and any other pertinent documentation, as determined necessary. During DHCS' review of the above listed items, DHCS determines a level of compliance with program policies and requirements. Should DHCS discover that a Waiver Agency has not satisfied or complied with its obligations under the HCBA Waiver, Medi-Cal, or other legal authority, DHCS may require the Waiver Agency to develop and submit to DHCS, a written CAP specific to correcting the issue(s). The Waiver Agency shall provide the required CAP to DHCS within 30 calendar days with a formal written plan of action to cover any identified issues. The CAP shall be specific about the actions to be taken, the personnel who will take the actions, and the completion date of the corrective action. DHCS will monitor the Waiver Agency's implementation of the CAP. When DHCS determines that the Waiver Agency has successfully remediated the issues identified in the CAP, DHCS will approve the CAP implementation. DHCS will provide the Waiver Agency technical assistance during the QAR and throughout the entire issue resolution process.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and**

participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Pursuant to 42 CFR 441.730(b), individuals or entities that evaluate eligibility or conduct the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan cannot:
• Be related by blood or marriage to the individual or to any paid caregiver of the individual;
• Be financially responsible for the individual;
• Be empowered to make financial or health related decisions for the individual; or
• Have a financial interest in any entity paid to provide care to the individual

Pursuant to 42 CFR 431.301(c)(1)(vi), case management (person-centered service plan development) must be separate from service delivery functions. A conflict occurs not just if the case management provider is also a service provider, but also if the case management provider has an interest in a provider or if they are employed by a provider. Any Waiver Agency, or other case management provider, that provides both case management and waiver services in violation of this rule without first obtaining written approval from DHCS, may be subject to sanctions, including but not limited to the required repayment to DHCS in the amount of all compensation received for providing the waiver services and the comprehensive care management during that time period.

In order for the Waiver Agency or other case management provider to deliver a service, they, must do the following:
• Demonstrate to DHCS that the only willing and qualified case manager is also, or affiliated with, a direct service provider.
• Work with DHCS to provide full disclosure to participants and assure that participants are supported in exercising their right of free choice in providers.
• Assure that the Waiver Agency or other case manager separates case management and service provision (different staff).
• Waiver Agencies, and any other entity that provides case management, are only permitted to provide both case management and services if they obtain the express written approval of DHCS. DHCS will directly oversee and periodically evaluate the safeguards put in place by the Waiver Agency or other case management entity to prevent any conflict of interest issues from occurring.
• The Waiver Agency or other case manager responsible for service plan development that seeks approval to provide waiver services must demonstrate to DHCS with supporting evidence all of the above listed requirements in order to seek approval to provide waiver services. This situation may arise in rural counties with limited providers, or when the Waiver Agency is the only culturally competent provider and the only culturally competent service plan developer available. If DHCS determines that the Waiver Agency or other case management provider that has been granted approval to provide waiver services is not complying with the above requirements, or if a conflict of interest issue has arisen, then DHCS has the authority to revoke that permission to provide waiver services.

DHCS will require Waiver Agencies to develop internal Policies and Procedures that describe the specific responsibilities of the CMT, and the distinct responsibilities of the direct care provider. The Waiver Agency will develop a full disclosure form for participants/families to sign prior to enrollment in the waiver in areas where the Waiver Agency is the only willing and qualified provider. The form will convey the following:
• Providing full disclosure and assurances that participants/families are supported in exercising their right of free choice in providers;
• Describing the individual dispute resolution process;
• Providing full disclosure that only one willing and qualified provider is available to provide case management and direct services in the participant's/family's county of residence;
• Providing assurance that the provider entity will separate case management and service provision (different staff with different lines of supervision);
• Providing assurance that the entity that provides case management and direct services does so only with the approval of the State; and
• That the State will provide direct oversight and periodic evaluation of effectiveness and appropriateness of established safeguards.

In cases where the Waiver Agency or other case management provider is also the only willing and qualified provider of direct services, the Waiver Agency or other case management provider must set up internal firewalls to restrict access for the case manager to view the service provider's case notes, and vice versa. Additionally, the Waiver Agency administrator or other case management provider will sign a formal agreement with the State verifying the willingness of the Waiver Agency or other case management provider to maintain a separation between waiver case management and direct services functions and lines of supervision. Lastly, the Waiver Agency or other case

management provider will require case management and direct services staff to sign agreements acknowledging their understanding of and willingness to comply with mandated separation of case management and direct service functions. This signed agreement will be submitted to the State and must meet the State's approval prior to that staff member being allowed to have any contact with any newly enrolled waiver participants or their families. DHCS shall periodically confirm that the signed agreement is implemented as described through ongoing monitoring and oversight consisting of, but not limited to of annual QARs and ad hoc/as needed onsite visits, quarterly progress report submission/review, and ongoing desk review of case documentation and billing.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

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 records that document that the participant, et al. were involved in the identification, development and management of services and supports for meeting the participant's assessed medical necessity care needs. Numerator: Number of case records showing involvement by the participant, et al. in development/management of services / Denominator: Number of case records reviewed.

Data Source (Select one):
Record reviews, on-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:

Performance Measure:
 # and % of case records documenting that the participant's medical necessity care needs (including health and safety risk factors) and personal goals are being met by the provision of waiver services, or through other means. Numerator: Number of case files documenting medical necessity care needs and personal goals are met / Denominator: Number of files reviewed.

Data Source (Select one):
Record reviews, on-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:

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

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: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

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 documentation indicating service plans are updated/revised

at least annually or when warranted by changes. Numerator: Number of case files with documentation indicating services plans are updated/revised at least annually / Denominator: Number of records reviewed.

Data Source (Select one):
Record reviews, on-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**

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

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 documentation indicating that services are being delivered in accordance with the POT. Numerator: Number of case records with documentation indicating that services are being delivered in accordance with the POT / Denominator: Number of records reviewed.

Data Source (Select one):
Record reviews, on-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:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

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 and/or legal representative, as appropriate, indicated they were afforded choice between/among waiver services and providers as verified by Waiver participant attestation in Patient Rights Form. Numerator: Number of case files documenting the participant was afforded choice between/among waiver services and providers/Denominator: Total number of case files reviewed.

Data Source (Select one):
Record reviews, on-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.

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.

DHCS assures that:

• The Waiver participant and/or their circle of support are involved in identifying and managing the waiver services that meet the participant's medical necessity care needs;
• The current primary care physician is in agreement that the participant is receiving the medical necessity waiver services to remain safely at home;
• The waiver service providers deliver those services as described on the participant's POT;
• The participant has been informed they have a choice to receive care in their home in lieu of facility care; and,
• The participant, the current primary care physician, and waiver providers have been informed of their rights and responsibilities under the waiver.

Waiver Agencies are responsible for discovery activities as well as analyzing the data collected during those activities. The Waiver Agencies will evaluate the findings discovered during monitoring and oversight activities and implement any remediation actions necessary to enhance, correct, and/or improve compliance with waiver assurances.

DHCS and the Waiver Agencies utilize the following tools for discovery:

• Internet-based MedCompass case file management system;
• Care management onsite review visits;
• Annual QARs;
• Case Record Review;
• Provider onsite visit and/or or live video conferencing meetings;
• Quarterly utilization reports (to be integrated in to MedCompass);
• Event/Issue Database (to be integrated in to MedCompass);
• California Department of Social Services Case Management Information Payrolling System (CMIPS); and,
• Management Information and Decision Support System (MIS/DSS)

MedCompass is a database that was implemented in December 2017. DHCS uses information from MedCompass to collect data on quality indicators to determine if changes need to be made to the waiver enrollment criteria, care management functions, services, providers, or any other aspect of waiver administration.
MedCompass stores data on how potential participants are referred to the waiver, how many referrals are received, and documents the timeliness of the referral, evaluation, and enrollment process.
MedCompass also enables DHCS and Waiver Agencies to store data on applicants who are placed on the waitlist, reasons active waiver cases are closed; utilization and cost of WPCS; Notices of Actions (NOA); and requests for State Fair Hearings along with the outcomes of those Fair Hearings.

DHCS is responsible for conducting annual onsite and/or electronic Waiver Agency QARs and, in areas of the State not covered by a Waiver Agency, DHCS conducts 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 indicted by the Sample Size Calculator, DHCS selects the cases for review based upon the corresponding percentage of participants at each LOC by the CMT.

During the QAR, the case record review uses a tool designed to document the following:

• Evidence of the LOC evaluation;
• Evidence that the participant, legal representative/legally responsible adult(s), and circle of support, which includes individuals identified by the participant, are involved in the development of the POT;
• Evidence that the POT addresses all of the participant's identified medical necessity care needs, personal goals, and the status of the participant's health and welfare;
• Evidence that the participant, legal representative/legally responsible adult(s), and circle of support have received instructional information in recognizing abuse, neglect, and exploitation and are knowledgeable about how to report them;
• Evidence that the POT reflects that all of the participant's medical necessity services are planned and

implemented in accordance with their unique medical necessity care needs, expressed preferences, personal goals and abilities, while maintaining the participant's health and safety;
• Evidence that information and support is available to help the participant, legal representative/legally responsible adult(s), and circle of support to make selections among service options and providers; and
• Evidence that the CMT is completing and maintaining the waiver participant's case report in compliance with DHCS' policies and procedures.

DHCS maintains an Event/Issue log, to track the type and number of reported events and issues that affect or can affect the health and safety of the waiver participant. The log also tracks the timeliness of reports and if law enforcement, Adult Protective Services, and/or the participant's current primary care physician, were notified.

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:

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 Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

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

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

HCBA Waiver participants and/or their legal representative have the opportunity to select and dismiss licensed and unlicensed care providers who, under the direction of the participant or legal representative, provide waiver services as described in Appendix C of this application. The ability for the participant to select, dismiss, and direct the services of their individual waiver providers supports the participant's:
• Freedom of choice in the provider of waiver services;
• Flexibility in scheduling the services to meet the participant's medical necessity care needs;
• Continuity of care; and
• Ability to direct the services that meet the participant's medical necessity care needs.

The CMT provides information on participant direction to the participant and/or legal representative at the face-to-face, intake assessment, and reassessment visits. During the visit the CMT explains the roles and responsibilities of the participant or legal representative, the participant's current primary care physician, DHCS, the Waiver Agency, and the providers of waiver services.

Upon request, the Waiver Agency will provide the participant, legal representative, and potential wavier provider(s) with the written requirements and process for providers to:
• Enroll as a waiver provider;
• Provide waiver services; and
• Submit documentation for payment of services rendered.

Participants or legal representatives selecting WPCS and/or paramedical services can select an unlicensed adult who is not the spouse, or legally responsible adult, parent, stepparent, or foster parent of the participant, and who is enrolled with the county's DSS IHSS program as a Personal Care Service (PCS) provider.

Participants or legal representatives may select individual licensed providers to provide the following waiver services:
• Case Management (in areas of the state where there are no Waiver Agencies)
• Habilitation Services
• Community Transition Services
• Continuous Nursing Services
• Private Duty Nursing
• Transitional Case Management
• Family Training
• Respite Care

The following licensed providers are eligible to enroll as individuals providing wavier services:

• Registered Nurse
• Licensed Vocational Nurse

Participants or legal representatives can obtain lists of unlicensed providers from their county's IHSS program. Lists of licensed providers are provided from the Waiver Agency or DHCS. Participants may also select any qualified, licensed or unlicensed, provider who is not yet enrolled as a provider, conditioned on their enrollment in Medi-Cal. Upon selecting an unlicensed or licensed provider not currently enrolled as a waiver provider, the Waiver Agency or DHCS will advise the potential provider of the Medi-Cal and/or IHSS or enrollment processes, and the roles, responsibilities, and requirements to become a waiver provider. In order for a provider of HCBA Waiver services to be compensated through the HCBA Waiver for providing waiver services, that provider must have satisfied all state Medi-Cal and federal Medicaid provider enrollment requirements at the time the service was delivered.

Prior to rendering care, unlicensed providers must demonstrate their ability to meet the care needs of the participant as described on the participant's POT. It is the responsibility of the participant or legal representative to determine if the unlicensed provider has the knowledge, skills, and abilities to meet the care needs of the participant. Upon request from the participant or legal representative, the unlicensed provider will receive training on providing appropriate services to meet the needs of the participant. This training can come from the participant, the participant's legal representative, the participant's current primary care physician, or the medical team. The medical team may include clinical staff from the participant's current primary care physician's office, other specialists, the Waiver Agency, and/or other licensed providers rendering waiver services. The CMT will document that the unlicensed provider has the knowledge, skills, and abilities to meet the care needs of the participant.

Prior to rendering care, licensed providers that have been selected by the participant or legal representative must submit to the Waiver Agency, or DHCS in areas where there is no Waiver Agency, the required documentation that is described in the SOP for the individual's provider type. The Waiver Agency or DHCS will document that the licensed provider has the experience to provide the care as described in the participant's POT.

At each home reassessment visit, the CMT will interview the participant and/or legal representative about the unlicensed and/or licensed provider's knowledge, skills, and abilities pertaining to the provision of care described in the POT. This information will be documented in the CMR. Any identified issues with the unlicensed or licensed provider's delivery of waiver service(s) will be discussed with the participant or legal representative, and remediated to safeguard the participant's health and safety. The CMT will interview the participant or legal representative about the effectiveness of the remediation. In the event issues affect or may affect the health and safety of the participant, the CMT will complete an Event/Issue Report, contact the participant's current primary care physician, and the appropriate law enforcement or child/adult protective services, as applicable. The CMT must also notify DHCS of the problem and of actions that were taken, as soon as reasonably possible.

The CMT instructs the participant or legal representative to notify the Waiver Agency or DHCS if the participant is subject to abuse, neglect, and/or exploitation. The CMT also advises the participant or legal representative on how to report such incidents to the appropriate authority, such as, law enforcement, child or adult protective services and/or the individual's licensing board.

Prior to authorizing waiver services, the Waiver Agency notifies the participant's current primary care physician who reviews and authorizes the participant's home program that the participant or legal representative has selected an unlicensed and/or licensed provider who is enrolled to work under the direction of the participant or legal representative and is not an employee of an organization or agency.

The Waiver Agency and DHCS must be in receipt of a current POT prior to authorizing waiver services. The current POT must include descriptions of the waiver and non-waiver services the participant receives, who provides those services, and must be signed by the participant or legal representative, the participant's current primary care physician overseeing the participant's home program, and the CMT or HCBA Case Management Providers (Nurse and Social Worker) who prepared the POT. Authorization of all waiver services can only be made by the Waiver Agency, or by DHCS in areas where there is no Waiver Agency.

The following supports are available to assist HCBA Waiver participants hire, supervise, and dismiss employees providing participant-directed services:
1.County and Public Authorities: The County and Public Authorities maintain Registries of providers who are interested in working for participants and offers access to training for both consumers and providers. Regardless of whether a participant hires a provider from the Registry, participants can attend any of the available trainings. Public Authorities may also have newsletters available to participants who wish to receive ongoing information about available services and supports.
2.IHSS/WPCS Consumer Handbook: Developed based on priorities identified by IHSS consumers, providers, county and public authority staff, state agency personnel, representatives of advocacy organizations and homecare provider unions, the handbook is intended to supplement trainings provided by County and Public Authorities, and to provide participants with a resource available to them in their homes.
3.Independent Living Centers (ILC): Provide services to people with disabilities to support self-determination, which includes (among other services) providing training to people on how to hire, train, and dismiss providers.
4.Area Agencies on Aging (AAA): Provide elderly as well as younger functionally impaired adults at risk of institutionalization with services ranging from in-depth information and assistance, peer support, advocacy, etc. to help participants retain independence and avoid institutionalization.
5.Designated Aging and Disability Resources Connections (ADRC) Partnerships: ADRCs provide comprehensive resource information, follow-ups, and referrals; and when requested, assist participants in identifying goals and needs through person-centered counseling and coordinating access to services and supports in the community.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Select one:

- ◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The CMT will provide information about participant direction opportunities to the participant or legal representative at the time of the initial face-to-face intake assessment. The opportunity is also described in the Informing Notice.

If the participant or legal representative expresses interest in selecting an unlicensed provider to provide WPCS, respite, and/or paramedical services, the CMT provides the participant with a Waiver Personal Care Information Packet, which describes the roles and responsibilities of the participant, legal representative, the participant's current primary care physician, the CMTs, and the unlicensed provider.
The packet includes the following information:
• The requirement for two or more personal care providers when a participant is authorized to receive 360 hours or more a month of combined IHSS and WPCS, and paramedical services;
• Waiver services can only be authorized after the Waiver Agency or DHCS receives a current, complete, and signed POT;
• Participant or legal representative is responsible for scheduling the unlicensed provider's hours of service;
• Participant or legal representative is responsible for signing the unlicensed provider's timesheet to signify s/he has validated that the hours on the timesheet were provided; and
• Participant or legal representative is responsible for notifying the Waiver Agency or DHCS when providers are hired and dismissed.

If the participant or legal representative elects to receive case management services by a licensed provider in areas where there is no Waiver Agency, DHCS provides the participant or legal representative with an Individual Provider letter.
The letter explains:
• The roles and responsibilities of selecting an individual provider;
• The participant or legal representative are responsible for scheduling the hours of service;
• The provider can only provide the services as described in the participant's current primary care physician-signed POT; and
• The participant or legal representative is responsible for notifying DHCS when providers are hired and dismissed.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Family/Caregiver Training	☒	☐
Medical Equipment Operating Expense	☒	☐
Personal Emergency Response (PERS) Installation and Testing	☒	☐
Personal Emergency Response Systems (PERS)	☒	☐
Environmental Accessibility Adaptations	☒	☐
Home Respite	☒	☐
Habilitation Services	☒	☐
Transitional Case Management	☒	☐
Facility Respite	☒	☐
Waiver Personal Care Services (WPCS)	☒	☐
Community Transition Services	☒	☐
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	☒	☐
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	☒	☐
Paramedical Service	☒	☐
Private Duty Nursing - Including Home Health Aide and Shared Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☐ **Private entities**

◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case Management services, furnished by way of Comprehensive Care Management in areas where a Waiver Agency is available, assists the participant in developing the POT, which is reviewed and signed by the participant's current primary care physician. The Waiver Agency or DHCS must have a participant's current primary care physician signed-POT prior to approval of waiver services.

The HCBA Waiver Agency CMTs monitor the provision of services, including participant-directed services, by documenting discussions with the participant and waiver providers regarding the adequacy of care the participant is receiving and the abilities of, and satisfaction with, their caregivers during home visits with the participant.

Waiver Agencies' CMTs are responsible for:
1.Explaining in detail, the role and responsibility of the participant (and as appropriate, the legal representative, family, and/or circle of support) directing their own services.
2.Working with the participant, legal representative, and the circle of support to determine the participant's willingness and ability to be responsible for directing their own services.
3.Informing the participant about their freedom to choose their providers, their rights under the Waiver, and the grievance process.
4.Support the participant with the development of the emergency back-up plan when developing the POT.
5.Providing information to the participant on how to recognize and report critical incidents.
6.Monitoring services directed by the participant, in addition to the employer supervision provided by the participant (if applicable), in order to ensure quality of care and to protect the health and safety of the participant.

In areas where a Waiver Agency is not available, DHCS provides information and assistance to the waiver participants or legal representative. The information is provided verbally during the initial face-to-face assessment for waiver enrollment and at each reassessment visit. The information is also provided in writing in the Informing Notice. Upon enrollment in the waiver, the participant is assigned a DHCS MC.

The DHCS MC advises the participant or legal representative of their option to select participant-directed services and providers at each reassessment visit, and/or upon participant or legal representative request. Evidence of the participant being informed of the option is documented in the CMR, copies of the Informing Notice, and is filed in the participant's case record.

At each participant's reassessment visit the DHCS MC interviews the participant or legal representative about the provider's effectiveness and ability to provide the services as described in the POT. At each annual provider visit, the DHCS MC assesses the licensed provider's documentation of the services provided and the participant's response to the services that are being provided per the POT. Information from the interview on the provider's ability to provide the care is documented in the CMR.

It is the responsibility of the participant or legal representative to assess the performance of the provider. The DHCS MC advises the participant or legal representative to inform DHCS of any issues or problems and to notify the appropriate enforcement agency, child or adult protective services, county IHSS office, and/or licensing board in the event of abuse, neglect, and/or exploitation. Only the participant or legal representative has the ability to select or dismiss an individual provider.

Upon DHCS hiring of qualified RN staff at the state, the State Controller's Office issues pay warrants on a monthly basis as is the customary process for all State employees.

The performance of the DHCS RN that furnishes information and assistance is assessed by DHCS Supervisory review and approval of the IMS/CMR and MOHS completed after each initial assessment/reassessment, review of annual provider visits, and ongoing case notes.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Family/Caregiver Training	☐
Medical Equipment Operating Expense	☐
Personal Emergency Response (PERS) Installation and Testing	☐
Personal Emergency Response Systems (PERS)	☐
Environmental Accessibility Adaptations	☐
Home Respite	☐
Habilitation Services	☐
Transitional Case Management	☐
Facility Respite	☐
Comprehensive Care Management	☒
Waiver Personal Care Services (WPCS)	☐
Community Transition Services	☐
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	☐
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	☐
Case Management	☒
Continuous Nursing and Supportive Services	☐
Paramedical Service	☐
Assistive Technology	☐
Private Duty Nursing - Including Home Health Aide and Shared Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

HCBA Waiver participants can elect to terminate participant direction services at any time. The participant or legal representative is advised to call the participant's assigned CMT if they wish to terminate services. The CMT will provide the participant or legal representative with a list of alternate waiver providers to select from and update the POT accordingly. Upon the participant's identification of an alternative provider the CMT will work with the existing provider and new provider in transitioning the waiver services to help prevent a break in waiver services. The POT must be reviewed and signed by the participant or legal representative, the participant's current primary care physician, the CMT, or other case management provider in areas of the State not Covered by a Waiver Agency, who prepared the POT.

If the participant or legal representative is unable to secure an alternative waiver provider, the CMT, or other case management provider in areas of the State not covered by a Waiver Agency, will offer to transition the participant to a licensed medical facility until a new waiver provider is secured.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The Waiver Agency or DHCS may elect to terminate authorization of participant directed services for the following reasons:
• Lack of a participant's current primary care physician-signed POT describing all the participant's care services, provider(s) of services, and/or the frequency of the services;
• Participant or legal representative require services that are not included in the POT or beyond the scope of practice of the licensed provider; and
• Participant or legal representative are unable to keep providers as demonstrated by frequent voluntary termination of the services by the provider, and/or the participant's or legal representative's refusal to follow the provider enrollment process as described in the provider information packets.

Termination of waiver services will only occur after all attempts by the Waiver Agency or DHCS to train and inform the participant or legal representative about the roles, responsibilities, and requirements of participant directed services have been exhausted, or the participant or legal representative refuses to receive training on selecting and managing their providers.

The Waiver Agency or DHCS will provide the participant or legal representative with a NOA informing them of the decision to terminate participant directed services along with a written explanation of their appeal rights.

Safeguards to protect participant health and welfare, and continuity of services during the transition from participant directed services to provider managed services include documented coordination between DHCS, the CMT and the existing and/or new providers. Coordination of care will help maintain the quality of care and continuity of care provided to the participant. The development of an updated POT that identifies the waiver services as provider managed and the change in authorized services which must be reviewed and signed by the participant or legal representative, the participant's current primary care physician, the CMT and the providers of waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	3745	
Year 2	4373	
Year 3	5106	
Year 4	5962	
Year 5	6962	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports

are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

DSS, DHCS, counties, and public authorities act acts as a common law employer for WPCS and paramedical service providers, as specified in statute. Unlicensed providers must enroll as an IHSS provider at the county's DSS office. Payment for WPCS and paramedical services is processed through DSS' CMIPS.

In addition to Waiver Agency CMTs' oversight and monitoring of participant-directed services to ensure quality of care and to protect the health and safety of the participant, the following mechanisms are in place to ensure participants maintain authority and control over employees:
1.WPCS time sheets must be signed by the participant twice a month for a provider to receive payment for providing WPCS or Paramedical services.
2.Participants select, hire, supervise, and train providers and can fire a provider for any reason. If the participant has more than one provider, the participant decides how many hours each provider will work of the total authorized.
3.Participants are encouraged to train providers on their unique care needs and preferences.
4.Waiver Agency CMTs inform participants about their freedom to choose their providers, their rights under the Waiver, and the grievance process.
5.Waiver Agency CMTs provide information to participants on how to recognize and report critical incidents.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☐ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

No variation from Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☐ **Discharge staff (common law employer)**
- ☒ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the state's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Upon denial of initial enrollment into the HCBA Waiver program, or when a service has not been approved as requested, is reduced, terminated, or denied by the Waiver Agency or DHCS, the entity making the determination will issue a NOA, "State Fair Hearing Notice Request" form, and the informational letter "Your Right to Appeal the Notice of Action." The NOA, hearing request form, and the informational letter are mailed to the participant and/or legal representative/legally responsible adult(s) by the Waiver Agency or DHCS.

In the event of a reduction or termination of continuous and previously authorized services, the Waiver Agency or DHCS mails the NOA, hearing request form, and informational letter to the participant, her legal representative/legally responsible adult(s), the participant's current primary care physician, and the waiver service provider at least 10 calendar days prior to the effective date of the action.

The NOA advises the participant of the Waiver Agency or DHCS' decision and the reason(s) to: 1) terminate or deny waiver enrollment; 2) reduce or terminate previously authorized waiver services; or 3) deny or modify new waiver services. The NOA includes instructions advising the participant and/or their authorized representative(s) on how to request a State Fair Hearing before an Administrative Law Judge (ALJ), and how to request continuation of services pending the outcome of the State Fair Hearing. The participant must request a State Fair Hearing within 90 calendar days after the date the NOA is mailed to the participant.

If the request for a State Fair Hearing is submitted to the DSS Hearings Division prior to the expiration date printed at the top of the NOA, or within ten (10) calendar days of the date of the notice, the participant's waiver enrollment and/or previously authorized services will continue without interruption pending the outcome of the State Fair Hearing. The participant and/or their legal representative/legally responsible adult(s) are responsible for submitting the request for a State Fair Hearing before the action takes place. A copy of the NOA and the fair hearing request form is filed in the participant's case record maintained by the Waiver Agency or DHCS.

State Plan and waiver services unaffected by the NOA will continue to be provided as authorized. The participant's Medi-Cal eligibility is not affected by a NOA, unless the NOA specifically indicates that the action taken with respect to the HCBA Waiver will impact the Waiver participant's Medi-Cal eligibility.

Upon request of a State Fair Hearing, the Waiver Agency or DHCS staff will contact the applicant or participant and/or their legal representative/legally responsible adult(s) to provide them with additional information on the State Fair Hearing process, and advise them they will receive the Waiver Agency or DHCS' written position statement before the scheduled hearing date. If the participant and/or their legal representative/legally responsible adult(s) have not identified legal representation, the Waiver Agency or DHCS will refer the participant and/or their legal representative/legally responsible adult(s) to the toll- free phone number on the back of the NOA for information regarding hearing rights, free legal aid, and information regarding Protection and Advocacy, Inc. The Waiver Agency or DHCS will continue to work with the participant and/or their legal representative/legally responsible adult(s) to resolve the hearing issues before the scheduled date of the hearing. If a hearing is held and the DHCS Director's Decision upholds the Waiver Agency or DHCS' action that is being appealed, any aid paid pending the outcome of the State Fair Hearing will stop.

The participant may request a rehearing. Instructions on how to request a rehearing, and the grounds upon which a rehearing can be requested, are included with the ALJ's written decision. To request a rehearing, the participant must mail a written request to the address indicated in the instructions within 30 calendar days of the final decision. The participant must state the date the decision was received and the reason(s) why a rehearing should be granted. A request may be granted if the participant submits evidence that was not reasonably available at the time of the hearing that could change the outcome of the original decision. The Director may deny the request, or order the ALJ to conduct a rehearing on one, several, or all issues that were presented for review in the original State Fair Hearing.

If the participant is unsatisfied with the outcome of the original hearing or rehearing, s/he can elect to seek judicial review by filing a petition in Superior Court within one year of receiving notice of the final decision adopted by the DHCS Director. The participant may file this petition without first requesting a rehearing.

The following are some, but not all, reasons, each alone or in conjunction with each other, for issuing a NOA affecting the participant's enrollment in, or benefits received under, the waiver:

• The participant loses Medi-Cal eligibility.
• There is no evidence establishing the medical necessity of the requested waiver services.
• The participant moves from the geographical area in which the HCBA Waiver services were authorized to a new area where there is no Waiver Agency, and no provider has agreed to render waiver services to the participant.

• In areas where there is no Waiver Agency, the participant's medical condition resulting in frequent emergency hospitalization is unstable as demonstrated by repeated, unplanned hospitalizations, and the waiver does not provide enough medical necessity services and supports to protect and sustain the participant's health and safety in the community
• The participant's condition does not meet the medical eligibility criteria for an evaluated LOC described in the waiver.
• The participant or the legal representative/legally responsible adult(s) refuses to comply with the participant's current primary care physician's orders in the POT, and the Waiver Agency or DHCS determines that such compliance is necessary to assure the health, safety, and welfare of the participant in a community-based setting.
• The participant or the legal representative/legally responsible adult(s) does not cooperate in attaining or maintaining the goals identified in the POT, thereby jeopardizing the participant's health and welfare.
• The identified support network system or a primary caregiver cannot be identified, is not able, or is no longer willing or available, to assume the responsibility to act as a backup caregiver for the participant. The Waiver Agency or DHCS will work with the participant and responsible persons to develop a POT and identify providers so the participant can continue to reside safely in a home-like setting, when possible.
• The home evaluation completed by the Waiver Agency, or DHCS in areas where there is no Waiver Agency an HCBS provider, documents an environment that does not support the participant's health, safety and welfare, or is otherwise not conducive to the provision of HCBA Waiver services.
• The HCBA Waiver service provider is unwilling or unable to provide the amount of authorized services as order by the participant's POT and/or primary care physician's order. If this inability to provide services impacts the health and safety of the participant, at the request of the participant and/or the legal representative/legally responsible adult(s), DHCS shall assist by identifying and authorizing services to be provided by a licensed health care facility, until another HCBA Waiver service provider accepts the responsibility for providing services in the home setting.
• Any documented incidence of noncompliance by the participant or legal representative/legally responsible adult(s) with the requirements of this agreement and/or any failure to comply with all regulatory requirements.
• A Participant is found to be a threat or harm to others with who they are residing or from whom they are receiving services, including but not limited to caregivers or service providers, care managers or the community at large; or are unable to safely integrate into social settings to protect the health and safety of the Participant's circle of support.
• The participant, legal representative/legally responsible adult(s), and/or circle of support are requesting direct care services that exceed 24 hours per day, and do not agree to a reduction of services so as not to duplicate services.
• The participant receives 360 hours per month or more of combined IHSS, WPCS, and paramedical services, has not been issued an overtime exemption by DHCS, and does not have two (2) or more personal care providers to protect the safety of the participant.
• In areas where there is no Waiver Agency, the participant, legal representative/legally responsible adult(s), participant's current primary care physician, or waiver service provider, has not submitted to DHCS a complete and current POT that is signed by the participant's current primary care physician, within 90 days of notification that they are eligible for enrollment in the HCBA Waiver or within 60 days of the end-date of the previous POT.
•The Waiver Agency or DHCS has not authorized a waiver service within 90 days of notification that the participant is eligible for enrollment in the HCBA Waiver or within 60 days of the termination date of the last authorized waiver services.
•Participant has been residing in an institutional setting for more than 30 consecutive days.

In the event of a reduction or termination of waiver services and/or enrollment, the Waiver Agency or DHCS will assist the participant in identifying local community resources that may be available.

Individuals are informed about the State Fair Hearing process during entrance into the HCBA Waiver program. Upon initial enrollment or denial of enrollment individuals are given the Informing Notice, NOA, State Fair Hearing Notice Request, and Your Right to Appeal the Notice of Action.

All NOA and supporting documentation is stored in the MedCompass case management system, to which both DHCS and Waiver Agencies have access to their assigned caseload.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

○ **No. This Appendix does not apply**

◉ **Yes. The state operates an additional dispute resolution process**

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

DHCS continually reviews all information submitted by the Waiver Agency and any other sources of information regarding participant complaints and grievances, and instances of abuse, neglect, and/or exploitation. Contracts between DHCS and Waiver Agencies require Waiver Agencies to implement and maintain written grievance policies and procedures describing the submission, documentation, evaluation, and resolution of all participant grievances.

Waiver Agencies design policies and procedures that fit their unique operational structures and the participants they serve. Grievance policies and procedures are subject to review and approval by DHCS during the QAR and as necessary. DHCS provides technical assistance to Waiver Agencies handling complaints, grievances, and complicated situations. Waiver Agencies report in their QPRs all complaints, grievances, and outcomes. Medi-Cal State Fair Hearings serve as an additional dispute resolution method for participants. A participant's right to receive a State Fair Hearing is preserved if a participant elects to make use of the grievance process. Participants shall be informed that the employment of the additional dispute resolution mechanism does not serve as a prerequisite or substitute for a State Fair Hearing.

All NOA and supporting documentation is stored in the MedCompass case management system, to which both DHCS and Waiver Agencies have access to their assigned caseload.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

○ **No. This Appendix does not apply**

◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

DHCS

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

Waiver Agencies must implement and maintain policies and procedures that describe the submission, documentation, evaluation, and resolution of participant grievances. Grievances are categorized as verbal or written complaints. This grievance/complaint procedure is a mechanism to address participant expressions of dissatisfaction that are outside of the scope of the State Fair Hearing Process. The filing of a grievance or complaint is not a pre-requisite to the filing of a State Fair Hearing, regardless of whether the grievance should or could be addressed in a Fair Hearing.

A verbal complaint consists of any expression of dissatisfaction by a participant to the Waiver Agency or DHCS, in person or by telephone. For example, a participant may verbally complain that their qualified case manager does not return phone calls in a timely manner. The Waiver Agency or DHCS responds to verbal complaints verbally. Verbal complaints are usually resolved within 72 hours. The Waiver Agency or DHCS is responsible for documenting the verbal complaint and resolution.

A written complaint is considered a formal complaint and consists of any written expression of dissatisfaction by a participant to the Waiver Agency or DHCS. Although some Waiver Agencies design forms for participants to use when submitting written complaints, use of these forms is not obligatory. When written complaints are received, Waiver Agencies or DHCS must record each complaint in a complaint log. Different levels of staff may be involved in the written complaint review process.

Waiver Agencies or DHCS provide written assurances that any participant who requests or needs assistance with the submission of a complaint shall receive it. The Waiver Agency or DHCS presents and reviews these assurances with all participants at the time of enrollment and upon request. Upon completing the review of the complaint, the Waiver Agency or DHCS provides the participant a signed confirmation of receipt.

Waiver Agencies are required to submit a list of grievances and complaints that have been filed along with their resolution to DHCS on a quarterly basis as part of their QPR.

All Waiver Agency and DHCS grievance policies and procedures are provided to the participant and/or the participant's legal representative in writing at the time of enrollment and upon request, and must address/include the following:
• A description of the process and general timelines for resolution of the complaint within the Waiver Agency. If a participant requests to have DHCS' contact information provided to them, their request cannot be refused by the Waiver Agency;
• Written information about Waiver Agencies' grievance policies, procedures, and form(s), if applicable, must be provided to the participant at the time of enrollment and upon request, and include telephone numbers for obtaining information on State Fair Hearing appeal rights;
• All grievances must be brought to the attention of the participant's qualified case manager for first-level resolution, and must be presented during the subsequent QAR;
• All grievances must be reviewed by the Waiver Agency or DHCS following submission of the grievance. Appropriate action is taken as a result;
• If a verbal complaint cannot be resolved by the participant's qualified case manager, the participant must be asked if they would like to submit a formal, written complaint;
• If a verbal complaint becomes a written complaint, the Waiver Agency must notify DHCS of the grievance in the subsequent quarterly progress report and provide DHCS information pertaining to the case. If the grievance is resolved, the Waiver Agency must notify DHCS of the resolution that was reached and/or the outcome; and
• Serious issues involving licensed providers are immediately reported to the appropriate licensing agency when DHCS becomes aware of such issues.
• If a participant is unwilling to substantiate a complaint, or provide details necessary to perform an investigation, the Waiver Agency is not obligated to continue investigating the complaint and/or seek resolution, and may close the case. The Waiver Agency shall notify the participant of its decision in writing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b*

through e)

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Waiver Agency or DHCS will act on and document all reported or observed critical events or issues that may affect the health, safety, and/or welfare of waiver participants or their service/care providers as they are discovered. Critical events or incidents are incidents of participant abuse, (verbal, sexual, physical, or mental) or neglect, incidents posing an imminent danger to the participant or service/care providers, fraud or exploitation (including misuse of participant's funds and/or property), or a dangerous physical environment. The Waiver Agency or DHCS provides instruction to the participant, legal representative/legally responsible adult(s), and members of the circle of support annually on how to report events or issues that affect or can affect the health, safety, and welfare of the waiver participant.

The Waiver Agency or DHCS will use the Event/Issue Report form to document concerns or problems expressed by the participant, legal representative/legally responsible adult(s), service/care providers, and/or circle of support. If an event/issue is observed by a waiver provider it must be reported to the Waiver Agency or DHCS within 48 hours. The report will be documented in the participant's case record and an Event/Issue Report will be completed.

The Event/Issue Report form includes:
• A description of the event or issue (the who, what, when, and where);
• Who reported the event or issue;
• All of the State and local agencies, the participant's current primary care physician, and law enforcement agencies that were notified and when;
• The plan of action to address/resolve the event or issue (who, what, when); and
• The resolution, and the date the issue was resolved.

The Event/Issue Report form will be updated to document the resolution of the event/issue.

Incidents of possible abuse, neglect, or exploitation require the Waiver Agency to report the incident immediately to the appropriate local or State agencies and to DHCS within 48 hours. The Waiver Agency and DHCS will adhere to the Health Insurance Portability and Accountably Act of 1996 to protect the participant's Personal Health Information is protected. The Waiver Agency or DHCS is responsible for documenting the referral in the participant's case record, including the agency and the name of the person(s) who received the referral and the person(s) responsible for conducting the investigation. Referrals are made to the following agencies:

• APS;
• CPS;
• Local law enforcement; and
• Appropriate licensing agencies.

The Event/Issue Report form is used to communicate with the CDPH, L&C on events/issues affecting participants that are related to HHAs, pediatric day health care (PDHC) providers, CLHFs, ICF/DD-CNs and CHHAs. L&C will determine if the provider is in compliance with the California Health and Safety Code §1736-1736.7 (CHHA), 1760-1761.8 (PDHC), 1250(i) (CLHF) and 1250(m) (ICF/DD-CN). After the Waiver Agency consults with DHCS, DHCS forwards the completed confidential Event/Issue Report to L&C with a request that L&C investigate when there has been:

• Failure by the waiver provider to report abuse or neglect of a waiver participant. L&C will also notify the appropriate local or State agencies.
• Failure to notify the participant's current primary care physician of a change in the participant's condition, if the participant is harmed by the failure of this action.
• Failure to inform the participant and legal representative/legally responsible adult(s) of the participant's "Patient Rights";
• Failure to comply with the participant's "Patient Rights";
• Failure to complete the appropriate documentation and/or notify the participant's current primary care physician of an incident;
• Failure to provide services or supplies included in the POT, ordered by the participant's current primary care physician, and that the provider agreed to provide;
• Inadequate or inappropriate evaluation of the participant's needs (e.g., weight loss not assessed);
• Inadequate notification to the participant when services or supplies are changed or terminated; and,
• Failure to act within a professional's scope of practice.

The participant's case record is updated to document the event/issue resolution and closure, along with L&C actions and/or recommendations. During L&C's investigation, the Waiver Agency or DHCS will continue to work with the waiver providers, the participant's current primary care physician, the participant, the participant's legal representative/legally responsible adult(s), and/or circle of support, to confirm that the participant receives needed services and can continue to reside safely in the home.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Waiver Agency or DHCS is responsible for informing and discussing how to identify and report issues of abuse, neglect or exploitation that impact the health, safety, and welfare of the participant, with the participant, legal representative/legally responsible adult(s), and/or members of the circle of support. The Waiver Agency or DHCS discusses the different types of abuse, neglect, or exploitation with the participant, as well as and how to recognize if any of these occur and whom to contact to report such events/issues.

Each waiver participant, their current primary care physician, and all waiver service providers receive the "Informing Notice" that includes a description of the roles and responsibilities of the participant, caregivers, the participant's current primary care physician, and the waiver service provider(s). It also includes information on how to notify the Waiver Agency or DHCS if there are any issues or concerns that may impact the safety, health, and welfare of the participant.

The CMT evaluates the participant for issues of abuse, neglect, and exploitation during the initial face-to-face visit, and at each reevaluation visit. The CMT is required to provide the participant, legal representative/legally responsible adult(s), primary caregiver, and/or members of the participant's circle of support with information on what constitutes abuse (physical, mental and emotional), neglect, and exploitation, and how to report these issues. The CMT documents these steps in the participant's CMR as well as any actions taken.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When an event/issue is observed by, or reported to, the waiver provider, the provider has the responsibility to notify the Waiver Agency or DHCS, and if applicable, other agencies (CPS, APS, or law enforcement). When an event/issue is identified by, or reported to, the Waiver Agency or DHCS, the Waiver Agency or DHCS will complete an Event/Issue Report form. The report is designed to document:

• Who the report is from, the type of event or issue;
• The date and time of the event/issue, if applicable;
• The location of the incident (participant's home, etc.);
• Details of the event;
• Involved parties;
• The source of the information;
• Individuals who have first-hand knowledge of the event;
• Whether the participant's current primary care physician was notified; and
• The name, address and phone number of the participant's current primary care physician and any other agencies or individuals that were notified.

The specific nature of an event or issue will determine if notification of others is warranted, e.g., CPS, APS, California Children's Services, Regional Center, law enforcement, and/or CDPH, L&C. Any contact made with other agencies or individuals will be kept confidential as required by law.

The Waiver Agency will discuss the issues with DHCS and develop a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by DHCS to verify they are appropriate, will result in a resolution amenable to the participant and/or legal representative/legally responsible adult(s), and will protect the participant's health, safety, and welfare. All contact made by the Waiver Agency or DHCS with a waiver provider, the participant's current primary care physician, the participant and/or the legal representative/legally responsible adult(s) related to the identified event/issue are confidential and clearly summarized and documented in the participant's case record by the Waiver Agency or DHCS. The Waiver Agency or DHCS will continue to follow-up with the waiver provider(s), the participant's current primary care physician, the participant, and, if appropriate, the legal representative/legally responsible adult(s), and other agencies, for resolution. The Waiver Agency or DHCS will keep the participant and/or legal representative/legally responsible adult(s) informed of the progress of the investigation and will continue to follow-up until the issue is resolved. If the issue is not resolved within 30 days, the Waiver Agency will discuss the issue(s) with DHCS and develop an alternative plan for resolution.

In the event a significant incident occurs, jeopardizing the health, safety, and/or welfare of the participant while under the care of a waiver provider, the waiver provider shall submit written documentation to the Waiver Agency or DHCS for review. The waiver provider and the Waiver Agency or DHCS will act immediately on any report of incidents placing the waiver participant or the provider in immediate or imminent danger, including contacting local law enforcement (when the event/issue is abuse, neglect, and/or exploitation), and/or APS or CPS, as applicable, and as required by law. Upon learning of or observing such events, the Waiver Agency will immediately fill out an Event/Issue Report and notify DHCS within 48 hours. When a determination has been made that other agencies or entities need to be involved in the response to, and resolution of, the event/issue, the Waiver Agency or DHCS will immediately contact the appropriate agency and provide the necessary information and documentation to assist in the investigation. The Waiver Agency will continue to follow-up with the appropriate agency, continue to update the Event/Issue Report and the participant of the situation and notify DHCS. When a waiver participant is in eminent threat of abuse or neglect, the CMT will talk to family members and arrange to remove the waiver provider immediately.

If it is proven that a waiver participant suffered an instance of abuse at the hands of a community-based facility, the facility will receive a notice of temporary suspension. DHCS will coordinate the temporary suspension and removing the waiver participant from the facility with A&I as DHCS will continue to pay the facility to care for the participant up to one month after the initiation of the temporary suspension. The CMT will identify an alternate placement location and will work in coordination with DHCS to move the Waiver participant within 30 days. During this 30-day period, the CMT will continue to work with the Waiver providers, the participant's current primary care physician, the participant and her/his legal representative, and circle of support to verify that the participant receives their medical necessity services. Immediate removal can be actuated if there is imminent danger to the participant. DHCS can effect immediate removal by working in coordination with the Waiver Agency, APS/CPS and the local Ombudsman to identify a safe placement. This placement may be temporary until an alternative permanent safe residence is identified. The CMT will continue to visit the participant in the facility to monitor their safety throughout the transition process.

The Waiver Agency or DHCS tracks events/issues referred to CDPH, L&C follows up with the participant and/or legal representative/legally responsible adult(s) to make sure the issue has been resolved and there is no longer any risk to the participant's health, safety, and welfare.

If a Waiver Agency is notified of the critical incident that occurred in a facility the Waiver Agency has contracted with, it is Waiver Agency's responsibility to complete an Event/Issue Report form, report immediately to the appropriate local agency, and report to DHCS by email or in writing within two business days or as soon as possible. The Waiver Agency will include the critical incident in the quarterly report sent to DHCS. If DHCS was notified of the critical incident in a place where there was no Waiver Agency, then DHCS will document the incident and report to pertinent department as warranted, such as CPS, law enforcement, L&C, etc.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHCS is the single state agency responsible for overseeing critical incidents. DHCS utilizes a process for tracking the reporting, documentation, remediation, and outcome of critical incidents. DHCS is responsible for the oversight of critical incidents where there is no Waiver Agency. In places where there is a Waiver Agency, it is the responsibility of the Waiver Agency to oversee, report, and respond to critical incidents.

In areas where there is no Waiver Agency, DHCS is responsible for the oversight of critical incidents. Critical incidents and events are reported to DHCS by the HCBA Case Manager or other HCBA Waiver provider. DHCS logs all critical incidents/events into the MedCompass database along with all follow up that is conducted until a resolution is met. DHCS is able to track the performance and outcomes through this database for reporting purposes.

In areas where there is a Waiver Agency, the Waiver Agency will report to DHCS within 24 hours and will include the incident in the QPR. During the annual audit, DHCS conducts case record reviews to determine: 1) if the case manager staff are completing and submitting the event report for all events that may or are affecting the participant's health and safety; 2) if an appropriate action plan was developed and the outcome of the action plan; 3) if systemic program issues exist that require remediation.

The Waiver Agency shall identify any reported incidents of abuse or neglect since the initial assessment or last reassessment. The Waiver Agency will complete the Event/Issue Report form and document it in the waiver participant's case file. Documentation must include a description of the event, who reported the event, who was notified, the action plan to address the event or issue, the resolution plan and the date of the resolution. The data will be used to identify trends or reoccurring issues, document the number of issues experienced by participants enrolled in the Waiver, document actions taken by DHCS and other involved entities, and document the outcomes of the actions. Waiver Agencies will have a program to track waiver participants and incident reports. DHCS will follow up with the Waiver Agency to monitor remediation and prevention of further similar events. Waiver Agencies will report critical incidents and issues in the Quarterly Utilization Report.

California's CPS and APS programs have primary responsibility to resolve reported events/incidents of abuse, neglect and/or exploitation. In the event that CPS or APS does not take timely and appropriate action, Waiver Agencies will notify local law enforcement if the issue continues. APS and CPS conduct investigations independently from DHCS and according to their own timeline. Their timeframe and processes for informing necessary parties of the results of any investigations, including the Medicaid agency are on an as requested basis. When CPS, APS, and/or local law enforcement are involved, the Waiver Agency is required to continue to monitor the Waiver Participant's health and safety to confirm the issues have been resolved.

Annual reviews along with quarterly reports are used to document reported critical incidents or events, the follow-up and the outcomes. The Waiver Agency or DHCS will keep the participant and the legal representative/legally responsible adult(s) informed of the progress of the investigation and will continue to follow-up until the issue is resolved. If the issue is not resolved within 30 days, the Waiver Agency will discuss the issue(s) with DHCS and develop an alternative plan for resolution. DHCS tracks and analyzes data submitted which includes; who the report is from, the type of event or issue, the date and time of the event/issue, the location of the incident, details of the event, involved parties, the source of information, individuals who have first-hand knowledge of the event, if the participants current primary care physician was notified and the name, address and phone number of the participant's current primary care physician and any other agencies or individuals that were also notified, to verify that the monitoring of remediation activities of all critical incidents and events are resolved.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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

The Waiver Agency or DHCS is responsible for monitoring and ensuring the health, safety, and welfare of waiver participants. This is accomplished through initial, scheduled, or unscheduled home visits by the CMT and/or via synchronous video conferencing contact with the participant, the participant's legal representative/legally responsible adult(s), waiver providers, and participant's current primary care physician. If the CMT observes or learns that restraints are being used, an Event/Issue Report form must be completed.

The Waiver Agency or DHCS must determine:
1. Whether the use of restraints is ordered by the participant's current primary care physician;
2. If a plan with criteria for the use and monitoring of restraints is documented in the participant's POT; and
3. If the plan is being followed by the caregivers and/or providers.

The use of physical restraints must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
A. Identify a specific and individualized assessed need.
B. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
C. Document less intrusive methods of meeting the need that have been tried but did not work.
D. Include a clear description of the condition that is directly proportionate to the specific assessed need.
E. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
F. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
G. Include informed consent of the individual.
H. Include an assurance that interventions and supports will cause no harm to the individual.

The Waiver Agency or Case Manager will be trained on the above requirements and must document when the training was done in a format acceptable to DHCS. Training should be reviewed annually and documented in a participant's case file.

Physical restraints may be used when they are "immediately necessary to prevent a resident from injuring themselves or others and/or to prevent the resident from interfering with life-sustaining treatment, and no other less restrictive or less risky interventions exist." CMS Memorandum S&C-07-22, June 22, 2007

Practices to protect the participant's health and safety during the use of physical restraints in the home include the use of alternative interventions prior to the use of restraints and strict adherence to the restraint protocol defined in the POT.

Waiver Agencies shall maintain policies and procedures regarding provider use of restraints that reflect regulatory compliance and include provider training requirements.

The CMT is responsible for adequately training the providers/caregivers in the home about the application and monitoring of physical restraints. The adequacy of the training may be verified through home visits to observe the participant, evaluate caregiver competency and review the POT. In areas not covered by a Waiver Agency, the waiver case management provider will perform the role of the CMT.

The CLHF, ICF/DD-CN, or PDHC may use physical restraints only in compliance with State and Federal regulations and statutes. The Waiver Agency or DHCS will confirm that the CLHF, ICF/DD-CN, or PDHC facility maintain internal policies and procedures that include staff education and training in the administration and monitoring of restraints. If a facility does not meet this requirement, the CLHF, ICF/DD-CN, or PDHC facility will not be permitted to serve as Waiver providers.

If the Waiver Agency or DHCS has determined that physical restraints used for a participant living in their home is appropriately authorized, but the POT does not address preventative interventions, the Waiver Agency or DHCS will assist the participant/legal representative and/or caregiver to identify alternative methods specific to the participant for inclusion in the POT and as ordered by the physician. The Waiver Agency shall maintain policies and procedures regarding provider use of restraints that reflect regulatory compliance.

Unauthorized use of restraints by an HHA, PDHC, CLHF or ICF/DD-CN is reported to and sanctions are imposed by the appropriate authorities to include CDPH, APS, CPS, and law enforcement. Sanctions regarding the use of unauthorized restraints in licensed facilities are imposed by CDPH per investigative findings and may include deficiencies, fines, or termination from Medicare and Medical programs. In the event unauthorized restraints in a facility has been identified, the Waiver Agency or DHCS will assist waiver participants and/or authorized representative to arrange for appropriate alternative placement. If there are additional Waiver participants remaining at the facility, DHCS shall take action to make certain that the remaining participants are not subject to the unauthorized use of restraints. Actions taken by DHCS could include but are not limited to; unannounced site visits, requiring the facility to submit a CAP, suspension of new enrollments, and suspension of the provider and transitioning all remaining waiver participants to other appropriate settings.

The unauthorized use of restraints in the home are reported to APS, CPS, and/or law enforcement.

The only restraints that are able to be used are Physical Restraints which are described as: “Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.” State Operations Manual (SOM), Appendix PP; CMS Memorandum S&C-07-22, June 22, 2007. CLHF or ICF/DD-CN may use physical restraints only in compliance with State and Federal regulations and statutes.

The use of physical restraints must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

A. Identify a specific and individualized assessed need.
B. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
C. Document less intrusive methods of meeting the need that have been tried but did not work.
D. Include a clear description of the condition that is directly proportionate to the specific assessed need.
E. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
F. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
G. Include informed consent of the individual.
H. Include an assurance that interventions and supports will cause no harm to the individual.

The HCBA Waiver Agencies must train CMT staff on the above requirements and must document when the training was completed in a format acceptable to DHCS. Training must be reviewed annually, documented, retained by the Waiver Agency for three years, and made available to DHCS upon request.
The State will ensure the Waiver Agencies maintain policies and procedures regarding provider use of restraints that reflect regulatory compliance and provider training requirements.
The CMT will verify that the providers / caregivers in the home have been adequately trained in the application and monitoring of physical restraints. This is achieved during home visits through observation of the participant and evaluation of caregiver competency and review of the POT. In areas not covered by a Waiver Agency the waiver case management provider will perform the role of the CMT.
The CLHF or ICF/DD-CN may use physical restraints only in compliance with State and Federal regulations and statutes. The Waiver Agency or DHCS will ensure the CLHF or ICF/DD-CN maintain internal policies and procedures that include staff education and training in the administration and monitoring of restraints.

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

If the Waiver Agency or DHCS determines that the participant's current primary care physician has not authorized the use of restraints, or the use of the restraints is not in compliance with the POT, the appropriate law enforcement agency, and/or APS or CPS be will contacted to report the incident.

Methods for detecting unauthorized and/or inappropriate use of physical restraints include observation and inquiry regarding the use of restraints during initial, scheduled, or unscheduled home visits by the CMT and/or via synchronous video conferencing contact with participants, legal representative/legally responsible adult(s), waiver providers and participant's current primary care physician. The CMT verifies that all requirements are followed through observation and interaction with the participant, if possible, review of the POT and evaluation of caregiver competency. In areas not covered by a Waiver Agency the waiver case management provider will perform the role of the CMT.

Methods for detecting unauthorized and/or inappropriate use of physical restraints in a CLHF, ICF/DD-CN, or PDHC facility and ensuring that all state requirements are followed include scheduled or unscheduled facility visits, observation of participant, discussions with assigned staff, medical record and policy and procedure review.

All serious incidents are reported to DHCS where they are reviewed and logged. DHCS has developed an internal tracking system in which incidents are recorded, along with information about the participant and the provider. By tracking this information DHCS is able to identify trends of incidents at all levels and prevent re-occurrences. During the annual audit, DHCS compares what is received in incident reports to what is on file with the providers to verify the State was informed of all incidents. If there is a discrepancy, DHCS may issue a letter of finding to the provider.

Data is collected during the yearly audit of participant and provider files. It is then aggregated in a spreadsheet, which allows for DHCS to identify trends and patterns among providers and participants based on performance measures. The trend/pattern analysis will enable DHCS to identify deficiencies for correction and to identify and take the necessary action(s) to prevent re-occurrences and create improvement strategies. MedCompass will include capacity to establish an audit schedule for incident reporting which will include a flag for completing trend analysis on reports received.

The Waiver Agency or DHCS shall report the unauthorized use of restraints by an HHA, PDHC, CLHF or ICF/DD-CN will also be reported to CDPH, L&C to investigate and follow up on their findings. The Waiver Agency and DHCS are responsible for monitoring CDPH, L&C's investigation and findings.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Waiver Agency, or DHCS where there is no Waiver Agency, is responsible for monitoring the health, safety, and welfare of Waiver participants. This is accomplished through initial, scheduled, or unscheduled home visits by the CMT and/or via synchronous video conferencing with the participant, their legal representative/legally responsible adult(s), service providers, and the participant's current primary care physician. If the Waiver Agency or DHCS observes or learns that restrictive interventions are being used without authorization, an Event/Issue Report form must be completed, and APS, CPA, and/or the appropriate law enforcement agency will be contacted to report the event. Unauthorized use of restrictive interventions by an HHA, PDHC, CLHF, or ICR/DD-CN will also be reported to CDPH, L&C for investigation and follow-up The Waiver Agency and DHCS are responsible for tracking CDPH, L&C's investigation and findings.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Waiver Agency, or DHCS in areas of the state without a Waiver Agency, is responsible for monitoring the health, safety, and welfare of Waiver participants. This is accomplished through initial, scheduled, or unscheduled home visits by the CMT or HCBA Case Management Provider, and/or via synchronous video conference sessions with participants, their representative/legally responsible adult(s), waiver providers, and the participant's current primary care physician. If the waiver provider, the Waiver Agency, or DHCS observes or learns that seclusion is being used, the Waiver Agency or DHCS shall complete an Event/Issue Report form and notify APS, CPS, and/or the appropriate law enforcement agencies. The Waiver Agency or DHCS shall also report the unauthorized use of seclusion by an HHA, PDHC, CLHF or ICR/DD-CN, to CDPH, L&C for investigation and follow-up. The Waiver Agency and DHCS are responsible for tracking the outcomes of CDPH, L&C's investigation and findings.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

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

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

conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

CLHF and ICF/DD-CN are responsible for managing the medication for Waiver participants residing in their community-based facility, unless the participant's current primary care physician has submitted an order for the participant to self-manage their medications.

A RN employed by the CLHF or ICF/DD-CN is required to complete an initial assessment of the participant that includes a review of the participant's prescribed medications to develop a medication management plan, which must re-evaluated/updated, as necessary, based on the participant's changing medication needs and the participant's current primary care physician orders. The RN documents the start date, stop date, dosage, and scheduled times of each medication to be provided.

Waiver participants residing in a CLHF or ICF/DD-CN may keep and take their own medications when authorized to do so by their current primary care physician. For those who need help with self-administration the CLHF or ICF/DD-CN staff will assist participants with self-administration or administer medications in accordance with their license, and as necessary.

CDPH makes, at a minimum, annual visits to the CLHF and ICF/DD-CN facilities. The Waiver Agency or DHCS also make annual visits. Regional Center staff visit the ICF/DD-CN facilities every 6 months. During these visits, each of these entities has both the authority and responsibility to monitor medication regimens and verify that the participants are receiving the correct, therapeutic medications as ordered and scheduled. This is achieved by reviewing the participant's current primary care physician's orders and the medication records. DHCS and the Waiver Agency document and address findings of potentially harmful practices with the CLHF or ICF/DD-CN and verify if appropriate corrective action was taken during a follow-up visit and/or subsequent program compliance review.

Medication management and administration monitoring is designed to detect potentially harmful practices through ongoing onsite review and evaluation of medication related policies, procedures, documentation and clinical practices. Monitoring is conducted by CDPH, Regional Centers, DHCS, and the Waiver Agency.

Through person-centered planning and risk identification / remediation, participants living in their own residence have a number of options available to them to assist with medication management; including, but not limited to: caregiver training, assistive technology such as medical alert devices and automated medication dispensers, paramedical services (under the State Plan and as a Waiver service) to administer medications, reviewing best practices with participants such as using a single pharmacy, incorporating medication into the participant's daily routine, using charts, etc.
Waiver Agency CMTs include medication monitoring as a part of the ongoing monthly contact with Waiver Participants to detect potentially harmful practices, ask about changes in medications and possible side-effects, etc.

Each quarter, DHCS, Department of Public Health (CDPH), and Regional Center staff meet to discuss participant reports generated for the meetings. Further, staff from DHCS, the Waiver Agencies, CDPH and the Regional Centers share information on an as needed basis to meet the needs of the participant and address any issues.

Waiver Agency CMTs conduct second-line medication monitoring as a part of the ongoing monthly contact with Waiver Participants to detect potentially harmful practices, ask about changes in medications and possible side-effects, reviewing medication administration (e.g., frequency, dosage, storage, preparation), etc. If the CMT identifies medication mismanagement or abuse, they will notify the prescribing physician, caregivers and circle of support and/or legal representative, and/or authorities, as appropriate.

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

State oversight is provided by CDPH at annual provider visits.

The Waiver Agency or DHCS performs extensive client chart reviews at annual provider visits and situations that include potentially harmful practices receive the appropriate follow-up. The Waiver Agency or DHCS, as well as licensed nursing staff of the CLHF or ICF/DD-CN residence, are trained to identify the concurrent use of contraindicated medications. If appropriate follow-up has not occurred, the Waiver Agency or DHCS provides education and training on corrective actions to handle such situations in the future. At subsequent program compliance reviews, the Waiver Agency or DHCS will follow-up regarding previous findings to verify that necessary changes have occurred and continue to be applied, and that corrective actions protect the participant's health and welfare. Through these reviews, the Waiver Agency or DHCS assesses and evaluates the regular management of participant medications by qualified nursing staff at the CLHF or ICF/DD-CN.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

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

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

Only a licensed nurse (RN or LVN) may administer a medication.

Unlicensed CLHF or ICF/DD-CN staff have the ability to assist Waiver participants by passing medications or opening syringes, and handing them to the participant; however, the participant must have the ability to self-administer the medication, or the services of an LVN or RN are required. This requirement is enforced by CDPH and DHCS.

Under the HCBA Waiver, the CLHF and ICF/DD-CN are required to have skilled nursing staff sufficient to meet the skilled nursing needs of all waiver participants. If the participant is unable to take medication without assistance, the CLHF or ICF/DD-CN is responsible for providing the licensed nurse, as needed.

The Waiver Agency or DHCS works with the CLHF or ICF/DD-CN nursing staff to confirm that persons responsible for the administration of medications are trained to provide appropriate medication management and client education. The Waiver Agency or DHCS documents any findings of harmful and/or noncompliant practices which are found and follows up with DHCS with their plan for resolution and tracks remediation efforts to improve program performance. The Waiver Agency, DHCS, and CDPH reviews the following:

• Medication storage;
• Self-administered medications;
• Medication procedures;
• Medication documentation;
• Scheduled and controlled drugs, usage, and storage; and
• PRN medications, usage, and disposal.

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

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

DHCS and CDPH make, at a minimum, annual visits to the CLHF and ICF/DD-CN. During these visits, DHCS and CDPH have the authority and responsibility to monitor medication regimens and confirm that the participants are receiving the correct, therapeutic medications as ordered and scheduled. This is achieved by reviewing the participant's current primary care physician orders and the medication records.

CLHF and ICF/DD-CN waiver providers must have skilled nursing staff (RN or LVN) in the residence at any time a participant is present. The skilled nursing staff is responsible for medication administration.

CLHF and ICF/DD-CN providers are required to document all medication errors and report the errors that constitute a risk to participant health and safety to the Waiver Agency or DHCS. The report must include information regarding the medication, the error, and the outcome to the extent that it is known at the time of the report.

In the event a participant self-administers medication in error, the CLHF or ICF/DD-CN RN will follow facility policies and procedures for clinical assessment and physician reporting.

Recordable medication errors include but are not limited to, errors in administration of a controlled substance, administration of a drug to which the participant has a known allergy, omission of a prescribed drug, accidental administration of a drug without a physician's order, drugs administered in the wrong dosage, at the wrong time or by the wrong route of administration.

Reportable medication errors include but are not limited to, errors in administration of a controlled substance, administration of a drug to which the participant has a known allergy, omission of a prescribed drug, and accidental administration of a drug without a physician's order and drugs administered in the wrong dosage. Medications administered at the wrong time or by the wrong route of administration may or may not be reported depending upon the risk of harm to the participant.

The Waiver Agency or DHCS documents any findings of harmful and/or noncompliant practices, follows up with the CLHF or ICF/DD-CN to obtain a plan for resolution, and tracks remediation efforts to improve program performance. Immediate actions taken by DHCS to remediate the issue could include but are not limited to: having the facility submit a CAP, suspending new enrollments, requiring the updating of internal policies and procedures, requiring additional staff training, conducting additional onsite visits, etc.

(b) Specify the types of medication errors that providers are required to *record:*

Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

(c) Specify the types of medication errors that providers must *report* to the state:

Medication errors that constitute a risk to the participant's health and safety and occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

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

Medication errors are reported to the Waiver Agency, DHCS and CDPH for follow-up at least quarterly.

During the annual audit, DHCS reviews the Medication Administration Record (MAR) along with the physicians orders associated with all waiver participants. If there is a discrepancy or an error, the State notates it in their findings and issues a letter of findings with a request for a CAP. Once a CAP is received from the provider and is approved by DHCS, a follow up visit is conducted by DHCS to verify that remediation of the issue has occurred. Upon DHCS' verification of remediation, the CAP is lifted.

All medication errors that are reported to DHCS are logged and reviewed. DHCS has developed an internal tracking system to record the incident along with information about the participant and the provider. By tracking this information DHCS is able to identify trends of incidents at all levels and prevent re-occurrences.

Information that is required when submitting this information to DHCS includes information regarding the medication, the error, and the outcome of the incident, to the extent that it is known at the time of the report. DHCS is able to review and aggregate this data for reporting purposes. Medication errors are reported to the Waiver Agency, DHCS and CDPH for follow-up at least quarterly. Overall performance is aggregated on a yearly basis for purposes of reporting in the 372 Report.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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 HCBA Waiver Event/Issue Reports that are appropriately documented in

the event/issue tracking system. Numerator: Number of Event/Issue Reports that are appropriately documented in the event/issue tracking system / Denominator: Total number of cases reviewed.

Data Source (Select one):
Critical events and incident reports
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 =
☒ **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**

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

Performance Measure:
 # and % of case records documenting that the CMT has discussed recognizing instances of abuse, neglect, or exploitation with the participant, family, and/or circle of support. Numerator: Number of case records documenting the participant/family/circle of support have been informed to recognize instances of abuse, neglect or exploitation / Denominator: Number of case records reviewed.

Data Source (Select one):
Record reviews, on-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:	☒ **Annually**	☐ **Stratified** Describe Group:

Waiver Agency		
	☐ **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:

Performance Measure:
 # and % of waiver agencies that provided training to Care Management staff on development and ongoing evaluation of person-centered risk mitigation plans in last 12 months. Numerator: Number of waiver agencies that provided training to Care Management staff on development and ongoing evaluation of person-centered risk mitigation plans in last 12 months/Denominator: Total number of waiver agencies

Data Source (Select one):
Training verification records
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 =
☐ **Other** Specify:	☒ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

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 events/issues reported to DHCS within the required timeframes identified in the Waiver Agency Contract. Numerator: Number of of events/issues reported to DHCS within the required timeframes identified in the Waiver Agency Contract / Denominator: Number of event/incidents reported.

Data Source (Select one):
Critical events and incident reports
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 =

☒ **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:

Performance Measure:
 # and % of reported events/issues that were appropriately reported to licensing/criminal justice authorities, in accordance with state mandated reporting

obligations. Numerator: Number of events/issues appropriately reported to licensing/criminal justice authorities, in accordance with state mandated reporting obligations / Denominator: Total number of reported events/issues

Data Source (Select one):
Critical events and incident reports
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 =
☒ **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**

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

Performance Measure:
 # and % of incidents reviewed involving abuse, neglect, exploitation and unapproved restraints that had a plan of prevention/documentation of a plan, developed as a result of the incident. N = Number of incidents reviewed with a plan of prevention/documentation of a plan developed as a result of the incident. D = Total number of incidents in these categories reviewed.

Data Source (Select one):
Critical events and incident reports
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 =
☐ **Other** Specify:	☐ **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:

Performance Measure:
 # and % of Waiver Agency remediation plans that are submitted after receiving a Corrective Action Plan issued by the State, in accordance with the HCBA Waiver Agency Contract. Numerator: Number of Waiver Agency remediation plans that are submitted in accordance with the HCBA Waiver Agency Contract / Denominator: Number of Corrective Action Plans for which a remediation plan was required

Data Source (Select one):
Trends, remediation actions proposed / taken
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 =
☐ **Other** Specify:	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

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 incidents of restrictive interventions with orders from the participant's current PCP with the supporting documentation required under the waiver.
Numerator: Number of documented incidents of restrictive interventions with orders from the participant's current PCP with the required supporting documentation /
Denominator: Number of documented incidences of restrictive interventions

Data Source (Select one):
Critical events and incident reports
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 =
☒ **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:

Performance Measure:
 # and % of instances in which the use of restraints was documented in the case file

and was in compliance with state policies on the use of restraints. Numerator: Number of incidents in which the use of restraints was documented in the case file and was in compliance with state policies on the use of restraints / Denominator: Total number of case files with documentation of the use of restraints

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 =
☐ **Other** Specify:	☐ **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**

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

Performance Measure:
 # and % of case files that do not include orders for the use of seclusion. Numerator: Number of files that do not include orders for the use of seclusion / 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 =
☐ **Other** Specify:	☐ **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:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated 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.

Performance Measure:
 # and % of case files documenting that the Waiver participant received an annual physical. Numerator: Number of case files with documentation indicating that the Waiver participant received an annual physical / Denominator: Number of case 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.

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, or DHCS in areas of the State not covered by a Waiver Agency, will act on and document all reported or observed critical events or issues that may affect the health, safety and welfare of waiver participants or their service/care providers, as they are discovered. Incidents of possible abuse, neglect, or exploitation require the Waiver Agency to report the incident to DHCS, appropriate local or State agencies, and/or law enforcement.

Following the annual QAR, DHCS will present an analysis of the findings to the Waiver Agency within 30 days. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the Waiver Agency within 30 days. Effectiveness of the remediation actions will be re-evaluated at the next QAR.

Once DHCS is informed of an unexplained death, the participant's name is removed from the Waiver within MedCompass, DHCS' Eligibility Division updates their eligibility in the system, and a NOA is sent to the participant's family to notify them that the participant's case file has been closed. Any actual "unexplained" death would be reported to a DHCS Case Manager, the appropriate law enforcement, and either APS or CPS for investigation.

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:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DHCS conducts regular and ongoing oversight of the Waiver Agencies for trending, prioritizing, and implementing system improvements, through two primary processes. On a quarterly basis, Waiver Agencies are required to submit QPRs; and on an annual basis, DHCS performs an onsite, desk, and/or virtual review of each Waiver Agency, called a QAR. The QPRs include reporting on application intake processing, new enrollments, dis-enrollments, grievances/appeals, provider appeals, provider qualifications, and incident reporting. DHCS monitors Waiver Agency performance through these reports using trend analysis to identify patterns, provides technical assistance to Waiver Agencies, requires corrective action, and/or schedules site visits to verify remediation, as determined necessary. During the annual QAR, DHCS reviews Waiver Agency case files to collect data used to measure performance, which includes but is not limited to; timeliness of assessments, re-assessments, and service authorizations; resolution of grievances/appeals and special incidents; etc. DHCS may also conducts Waiver participant and provider interviews during the QAR.

Quarterly Performance Report:
Analysis of the QPRs allows DHCS to determine that required documentation was completed on a timely basis, using the appropriate forms, and by appropriate personnel. The specific areas of review include administrative accountability, LOC assessments, timely completion of the POTs, timeliness of service authorization, provider qualifications, provider performance/complaints, and participant health and welfare.
When deficiencies are identified during DHCS' review of a QPR, DHCS informs the Waiver Agency of the findings in a formal letter that includes a request for a CAP specific to remediating the problems. The Waiver Agency is required to respond to DHCS with a written plan to remediate the deficiencies (CAP) within 30 calendar days of the date of the formal letter. The CAP must be specific about the actions to be taken, the personnel who will take the actions, and when the corrective action will be completed. Upon receipt of the Waiver Agency's CAP, DHCS monitors the resolution process to verify the remediation of the deficiency. Technical assistance is provided throughout the CAP development and implementation process on an as-needed basis.

DHCS will continue to monitor the Waiver Agency's ongoing implementation of the developed strategy, on a quarterly basis, to determine the effectiveness of the remediation and new practice(s), which may include an on-site follow-up visit to the Waiver Agency.

Quality Assurance Review:

DHCS performs annual onsite reviews, and/or electronic record reviews of each Waiver Agency, called QARs. DHCS aggregates the results of the QARs and discovery information to develop a statewide remediation approach which includes policy dissemination through the periodic Waiver Agency meetings, and HCBA Waiver policy letters, if needed. DHCS also provides onsite technical assistance or through on-going email and telephone contact with the Waiver Agency. DHCS uses this aggregate data to prioritize multi-Waiver Agency training events.

If DHCS discovers that a Waiver Agency has significant performance or compliance issues while conducting the QAR, DHCS will send a letter to the Waiver Agency to notify them of the finding(s) and that they must develop a written CAP specific to correcting the identified deficiency(ies). The Waiver Agency must provide the CAP to DHCS within 30 calendar days of the date in the written notification issued by DHCS.

The Waiver Agency's CAP must be specific about the actions to be taken, the personnel who will take the actions, and the expected completion date of the corrective action. The plan and associated actions will be monitored by DHCS and, upon successful remediation of the problem, the CAP would be closed out. Technical assistance would be provided during the QAR and throughout the entire issue resolution process.

Non-Critical Incidents and Grievances:

Waiver Agencies and DHCS will act on and document all reported or observed critical incidents that may affect the health, safety, and/or welfare of waiver participants or their service/care providers, as described in Appendix G of this Waiver. For events, incidents, or complaints that are not considered emergencies, DHCS will analyze the situation to determine whether a CAP is necessary. DHCS will work with the Waiver Agency to formulate the appropriate response to resolve a specific dispute or complaint, and/or or adopt a process to avoid similar events or incidents in the future. If necessary, DHCS may elect to utilize the QPR process outlined in this section to address the documented issues, issue a written request for a CAP, and verify the implementation and effectiveness

of the Waiver Agency's plan. DHCS will report the results of analysis or action(s) taken, in response to individual complaints to affected participants and their family/legal representative, as needed.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The results of DHCS' remediation activities are analyzed to measure their effectiveness. This analysis results in system changes to the QPRs, QARs, Waiver Agency onsite review tools, and to methods of policy dissemination, technical assistance, and training.

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

Every eighteen months preceding the submission of the CMS 372 Reports, DHCS reviews the effectiveness of existing quality assurance systems to determine continued efficacy. DHCS identifies and implements system changes. DHCS changes the Waiver Agency QAR process, onsite review tool, and the QPR to reflect systemic quality improvement strategies. DHCS solicits quality improvement input from the Waiver Agency during the quarterly meetings between DHCS and the Waiver Agency.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ◉ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**

○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

DHCS is responsible for performing the Single Audit Act. In cases where administration of a waiver is delegated to another agency, that agency is responsible for collecting the information from their contractors. Once collected, the Single Audit data is sent to the DHCS Audits and Investigations Division. Service providers contracted under a Waiver Agency and HCBA Waiver providers are not subject to the requirement of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104- 146).

DHCS regularly reviews provider payments as part of internal monitoring and oversight. Claims data is run through a business objects portal and allows the State to monitor which services being provided, at what frequency, and to which participants. All of this information allows the State to validate the information that is documented in the POT and in the LOC determination/redetermination. If DHCS finds a discrepancy, an audit may be triggered prior to the annual scheduled audit.

a. DHCS will review claims data on a quarterly basis to identify any unusual claiming patterns or anomalous high costs that may not be supported by a participant's LOC or POT. This Waiver Renewal is based on an aggregate cost cap; therefore, individual billings that appear higher or lower than expected would be considered a discrepancy.

b. The quarterly audits referenced above are DHCS audits of costs to verify that claims are appropriate, and may trigger an on-site review. An annual audit is also conducted by the Waiver Agency to monitor provider performance and adherence to waiver requirements. The annual audits are on-site Waiver Agency QAR and/or electronic record reviews, which review Waiver participant records, progress notes, assessments, re-assessments, screening documents, timeliness of action, Waiver participant plans of care, documentation of the audit trail, verification of service delivery, Waiver participant satisfaction and any other pertinent documentation. In areas of the state where there is no Waiver Agency, DHCS will visit providers on-site and/or conduct electronic record reviews to review the information and documentation above. The quality review referenced in the application refers to the annual QAR.

c. The results of the QAR include corrective action as appropriate. The Waiver Agency responds to DHCS; Letters of Finding with a formal CAP to address any deficiencies. Upon initial approval of the CAP, DHCS monitors the resolution process of the Waiver Agency to assess the remediation of the deficiency(ies). DHCS may, at its discretion, conduct an on-site follow-up visit to the Waiver Agency to evaluate the effectiveness of the new practice(s), and/or request submission of records for additional review by DHCS. The Waiver Agency does not receive a CAP approval letter until complete resolution has been verified by DHCS. Technical assistance is provided throughout the process on an as needed basis. DHCS provides ongoing technical assistance to Waiver Agency and requires quarterly reports from each Waiver Agency that include updates on enrollment levels, fiscal performance, and quality assurance activities. DHCS communicates regularly via telephone, email, and periodic meetings with the Waiver Agency.

d. DHCS conducts quarterly discovery activities based on a random representative sample size (confidence interval of 95% +/- 5%) of all Waiver claims to identify any discrepancies. DHCS will access either MIS/DSS or CMIPS to obtain evidence that a claim submitted by a Waiver Agency was billed appropriately for the HCBA Waiver provider delivering HCBA Waiver services and was reimbursed at the established rate for the service. DHCS uses the QARs to gather data for the Financial Accountability Review, which analyzes Waiver Agency and statewide trends to verify that payments are made timely to direct service providers, billed appropriately to the state, and assurance of Waiver Agency fiscal solvency. DHCS will provide problem resolution with technical assistance and training to the Waiver Agency, when necessary. Within 30 days of the Financial Accountability Review, DHCS will present an analysis of the findings to the Waiver Agency. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the Waiver Agency. DHCS will follow up on the effectiveness of any remedial action within 30 days. Remedial actions will be re-evaluated at the next scheduled QAR. DHCS refers issues concerning fraud to DHCS' Audits & Investigations (A&I) Division.

Payments for Waiver services are made through the approved California Medicaid Management Information System (CA-MMIS). The CA-MMIS Division administers the Medi-Cal claiming system and manages the State's third party FI contract.

Health Insurance, Portability and Accountability Act (HIPPA) compliant procedure Codes (HCPCS) are unique to each waiver service. Each Waiver Agency and Waiver service provider is only eligible to bill for the waiver services they have delivered. The billing is via standardized billing forms and claims are submitted to the FI for payment. Only recognized Medi-Cal providers are eligible to receive payment for providing for waiver services.

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

claims selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment.

DHCS' A&I Division is responsible for ensuring the fiscal integrity and medical necessity of Medi- Cal program services, including the HCBA Waiver. All claims submitted by Waiver and State Plan providers are subject to random review regardless of provider type, specialty, or service rendered.

A&I verifies that claims have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional documentation may result in suspension from the Medi-Cal program, pursuant to Welfare and Institutions Code, §14124.2, or collection of overpayments. A&I has three branches that conduct reviews using various methodologies to monitor program integrity and the validity of claims for reimbursement.

The A&I Medical Review Branch (MRB) performs essential medical reviews of non-institutional providers. Providers may also be subject to a more comprehensive review on a weekly basis known as a pre-checkwrite review. This review is based on a set of criteria, such as irregular billing patterns, designed to identify potential fraud or abuse. Providers selected for this more comprehensive review will receive an on-site visit by A&I staff. Many of these reviews result in program removal, monetary penalties, or less intrusive sanctions and utilization controls.

MRB also conducts Medi-Cal provider anti-fraud activities that include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program.

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

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

The A&I Investigations Branch conducts investigations of suspected Medi-Cal beneficiary fraud as well as preliminary investigations of provider fraud. A&I IB is also responsible for coordinating provider fraud referrals to the California State Department of Justice (DOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to the DOJ via the A&I IB.

A&I IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. A&I IB serves as DHCS principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

DHCS examines the provider records and compares the records with the authorized services. If the received claim is correct, DHCS will authorize payment through CMIPS. DHCS will contact A&I if claims are incorrect, to conduct a more detailed financial analysis in the event of suspicious billing practices. The state conducts routine audits, based on data mining and claim review, of all Medi-Cal billers, to verify the accuracy of paid claims.

Individual, unlicensed providers of WPCS claims are paid through DSS' IHSS program, CMIPS, developed and managed by HP Enterprise Services. HP Enterprise Services will continue to oversee the CMIPS system. CMIPS validates provider claims with authorized hours and will reject any claim that exceeds the monthly authorized hours. If the received claim is correct, CMIPS will authorize payment.

Electronic Visit Verification (EVV) Compliance

EVV is a telephone and computer-based system that electronically verifies in-home service visits. EVV systems are used to verify the type of service being provided; the individual receiving the service; date of the service; location of service delivery; the individual providing the service; and the time the service begins and ends. Pursuant to subsection I of §1903 of the Social Security Act (42 U.S.C. 1396b), all states must implement EVV for Medicaid-funded personal care services by January 1, 2020 and Home Health Care Services by January 1, 2023. California was granted a one-year good faith effort extension to implement EVV for Medicaid-funded Personal Care Services.

Phase I was implemented on January 1, 2022 and providers of Medi-Cal home and community-based PCS must be registered, trained, and using either the CalEVV system or an alternate EVV system. Phase II for home health care services

is anticipated to be implemented by January 1, 2023.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

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 claims that were paid at appropriate levels for rendered services, in accordance with Waiver Agency-approved TAR and the Primary Care Physician-signed POT. Numerator: Number of waiver claims that were paid at appropriate levels for rendered services, in accordance with Waiver Agency-approved TAR and the Primary Care Physician-signed POT / Denominator: Quality review sample size

Data Source *(Select one):*
Financial records (including expenditures)
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:*	☒ ***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 state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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 claims that were paid at the approved and published Medi-Cal reimbursements rates. Numerator: Number of claims paid at the approved and published Medi-Cal reimbursement rates / Denominator: Quality review sample size

Data Source *(Select one):*
Financial records (including expenditures)
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:*	☒ ***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.*

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.*

DHCS conducts ad hoc discovery activities based on a random representative sample size of all Waiver claims. DHCS will access either MIS/DSS or CMIPS to obtain evidence that a claim submitted by a Waiver Agency was billed appropriately for the HCBS Waiver provider delivering HCBA Waiver services and was reimbursed at the established rate for the service. DHCS uses the QPRs and QARs to gather data for the Financial Accountability Review which analyzes Waiver Agency and statewide trends to verify that payments are made timely to direct service providers, billed appropriately to the state, and assurance of Waiver Agency's fiscal solvency. DHCS will provide problem resolution with technical assistance and training to the Waiver Agency, when necessary.

Within 30 days of the Financial Accountability Review, DHCS will present an analysis of the findings to the Waiver Agency. Based upon the findings and level of compliance, remediation actions will be developed (CAP) and implemented within 30 days by the Waiver Agency. DHCS will follow up on the effectiveness of any remedial action within 30 days. Remedial actions will be re-evaluated at the next scheduled QAR. DHCS notifies A&I about issues concerning fraud.

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***

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

Public comments on rate determination methods are solicited during public meetings and through the public comment period(s). DHCS held three technical workgroups in which comments were solicited for rate determination.
Below is a description of the rate methodologies used to establish payment rates for HCBA Waiver services.

DHCS FEE SCHEDULE RATE METHODOLOGY:
Adoption of published provider rates can be found in the Current California Medi-Cal Fee Schedule published at: https://files.medi-cal.ca.gov/Rates/RatesHome.aspx

The HCBA Waiver rates are established through the State's Medi-Cal fee-for-service schedule, which are included in the DHCS Access Monitoring Review. Waiver members are case managed to monitor utilization of services and providers. Providers agree to the rates established in the fee schedule, which remain compliant with SSA a(30)(A). The fee schedule is updated annually due to Federal/State mandates, annual HCPCS updates, or more frequently if necessary, such as a result of increases to minimum wage. When new rates are established or changes to existing rates are made, the state submits an Operating Instruction Letter to the FI to update the rates. The FI has edits and audits in place to pay the established rates based on the fee schedule. DHCS confirms the fee schedule is identical to State Plan service rates.

On June 27, 2018, the Governor Brown signed Senate Bill 856 (Stats. 2018, ch. 30, §44, Item 4260-101-3305), which appropriated Proposition 56 funds, in part, to increase Medi-Cal rates for home health services and to increase payments for ICF DD-CNC services. The appropriation was applied to increase the payment rates for private duty nursing provided by RNs, LVNs, and CHHAs; and to increase payments for ICF DD-CNC non-ventilator and ventilator dependent services. The increases were adopted through the annual Medi-Cal budget process, which affords various opportunities for stakeholder participation. These increases did not result in a change to the rate methodologies.

Most adjustments to rates are tied to the annual HCPCS process (which may adjust codes/rates across multiple services and provider types), or other state/federal authorized/mandated adjustments. DHCS develops a policy justification for rate changes, outlines authorities relevant and needed to adjust the rates, and works with the FI to update rates.

DHCS Fee-For-Services Rates Division, in collaboration with ISCD have oversight responsibility for rate setting.

The services listed below (Family Training, Habilitation Services, Private Duty Nursing, and Respite) are based on the published provider rates paid to either an RN employed by an HHA or an RN that is an INP, an LVN employed by an HHA or an LVN INP, or an CHHA employed by an HHA that provides intermittent private duty nursing.

In areas where there are no Waiver Agencies, the state will continue to pay the existing published Medi-Cal provider rates found in the current Medi-Cal Fee Schedule. Adoption of published provider rates applies to the care management and like services paid to either an RN that is an Individual Nurse Provider (INP) and/or an LVN INP that provides community transition services, and/or transitional case management to Waiver participants. Rates paid for HCBA Waiver care management services to individual providers are published and updated, if applicable, in the Medi-Cal Provider Manual and notice of updates are sent to Medi-Cal providers by U.S. mail or by e-mail.

Continuous Nursing and Supportive Services are based on the published provider rates paid to a CLHF that were negotiated and agreed upon.

The DD/CNC, non-ventilator dependent and the DD/CNC, ventilator dependent waiver services rates were determined by adding the cost of sufficient nursing hours to provide nursing care that corresponds to each of the two LOCs provided by an ICF/DD-CN waiver provider to the State Plan approved daily rate authorized for an ICF/DD-N facility. The ICF/DD-N rate is set by the DHCS FFS Rates Development Division. These facilities are licensed and paid according to residents' LOC and the number of beds. Providers for developmentally disabled consumers have rates set above the median as the result of a court settlement in 1990. The basis of this methodology is that these providers are disproportionate share providers that typically have higher than 95% Medi-Cal census. In the case of the waiver, the census is 100% Medi-Cal beneficiaries.

The ICF/DD-CN waiver rates are published annually in the Medi-Cal Long Term Care Provider Manual. The effective date is August of each year. The rate methodology used for the ICF-DD-N is found in the State Plan: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

HCBS SERVICE:

• Family Training
• Habilitation Services
• Private Duty Nursing – RN, LVN, CHHA
• Respite
• Continuous Nursing and Supportive Services
• DD/CNC Non-Ventilator and Ventilator Dependent Services

HOURLY RATE METHODOLOGY:
Hourly rates established locally by county government/authorities are negotiated between each individual county and its contractors, consistent with applicable regulation promulgated by CDSS or DHCS.

HCBS SERVICE:
• Waiver Personal Care Services (WPCS)
• Respite (if provided by an unlicensed personal care provider)
• Paramedical Services

MEDIAN RATE METHODOLOGY:
In areas where Waiver Agencies are available, the State applies the median rate to the HCBA Waiver's Comprehensive Care Management service that would allow contracted Waiver Agencies to facilitate and receive fair reimbursement for delivery of HCBA Waiver services.

This methodology requires that rates negotiated with new providers may not exceed the Department's current median rate for the same service, or the statewide current median rate, whichever is lower. This methodology is defined in California Welfare and Institutions Code §4691.9 the Department may negotiate a rate that exceeds the median rate if necessary in order to pay employees no less than the statewide minimum wage or to provide a minimum of 24 hours or three days of paid sick leave annually. The rationale for negotiated rates will be reviewed by a Nurse Evaluator and Analyst from DHCS during the annual QARs.

While the law sets a cap on negotiated rates, the rate setting methodology for applicable services is one of negotiation between the Department and prospective provider. Pursuant to law the Department and provider must maintain documentation on the process to determine, and the rationale for granting any negotiated rate (e.g. cost-statements), including consideration of the type of service and any education, experience and/or professional qualifications required to provide the service.

The HCBA Waiver offers personal and attendant care services to waiver participants who request and are eligible for medical necessity services. Waiver participants who utilize the HCBA WPCS or paramedical services must also be eligible for and receive the IHSS State Plan benefit. WPCS, paramedical services, and IHSS are subject to the federal Department of Labor Fair Labor Standards Act (FLSA) requiring compensation for overtime and travel and wait time. California is compensating WPCS, paramedical, and IHSS providers time and a half for any hours worked over 40 in a workweek and limited travel time for providers who serve more than one participant.

The negotiation regulations for WPCS and unlicensed Respite are found in Welfare and Institutions Code §12302 and §10102, which state that State reimbursement can be available only within the constraints imposed by the annual budget act and state allocation plan, all of which must be reflected in state-approved individual county plans. Counties that exceed the constraints, run the risk of not receiving full reimbursement if the cost overrun was due to non-state mandated costs, i.e., costs within county control, or more expensive modes used beyond amounts approved in an individual county plan. The State verifies that the rates for WPCS, paramedical services, and unlicensed Respite are equitable based on the county's minimum wage rate to which it is equivalent. The rate for these services cannot exceed the county minimum wage rate.

HCBS Service:
• Case Management
• Community Transition Services
• Transitional Case Management

USUAL AND CUSTOMARY RATE METHODOLOGY:
Per California Code of Regulations (CCR), Title 17, §57210(19), a usual and customary rate "means the rate which is

regularly charged by a vendor for a service that is used by both Medi-Cal members and/or their families and where at least 30% of the recipients of the given service are not Medi-Cal members or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a Medi-Cal member and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual who is not a Medi-Cal member, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act."

HCBS SERVICE:
• Environmental Accessibility Adaptations
• Personal Emergency Response (PERS) (activation and monthly service charge)
• Medical Equipment Operating Expense

Environmental Accessibility Adaptations: The Waiver Agency secures the provider that has the lowest bid.

PERS and Medical Equipment Operating Expense: The Waiver Agency secures the provider with the lowest bid. Medical Equipment Operating Expenses are payable if over $20 up to a maximum of $75.

Rates paid for HCBA Waiver services are published in the Medi-Cal Provider Manual and the Current California Medi-Cal Fee Schedule and notices of updates are sent to Medi-Cal providers by U.S. mail or by e-mail notices.

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

The Waiver Agency is responsible for prior authorization of all HCBA Waiver services, verifying that the requested services are in accordance with the participant's POT, and that the services are medical necessity. HCBA Waiver service providers are responsible for submitting a TAR to the Waiver Agency for prior authorization of all HCBA Waiver services, except WPCS and paramedical services benefit. The Waiver Agency reviews the TAR for medical necessity and to verify services are authorized in accordance with the participant's POT. Claims for services are paid to Waiver providers after the service is rendered.

DHCS CA-MMIS Division has overall responsibility for processing payments of Medi-Cal claims for provided services. The CA-MMIS Division oversees the contract with the FI that is responsible for managing the CMS approved CA-MMIS.

Waiver Agencies, and HCBA Waiver providers in areas where there is no Waiver Agency, submit claims to the Medi-Cal FI for services rendered using either a CMS 1500, UB 92 or UB 04 claim form. In areas where there are Waiver Agencies, HCBA Waiver providers may bill Medi-Cal directly, rather than through the Waiver Agency; however, authorization to provide services must be adjudicated through the Waiver Agency and the provider must provide proof of the service authorization from the Waiver Agency when submitting claims to the FI for payment. These claims are subject to all established requirements for processing directly through the CA-MMIS system.

The FI processes claims for services, resulting in one of four possible actions:
1. Paid (claim is paid);
2. Denied (claim is denied);
3. Suspended (FI staff perform further research); or
4. Additional information is requested (a Resubmission Transmittal Document (RTD) is sent to the provider requesting additional information).

Claims passing all edits and audits are approved on a daily basis, and the Medi-Cal FI forwards a payment tape to the State Controller's office for a weekly checkwrite, and the provider is notified through a Remittance Advice Detail form.

WPCS claims by unlicensed individual care providers are paid through CDSS' CMIPS.

The CMT authorizes WPCS and/or paramedical service hours by contacting DHCS to determine if the participant is authorized to receive In-Home Support Services (IHSS), and how many hours of IHSS they are currently authorized to receive. If the CMT determines it is necessary to authorize WPCS and/or paramedical hours, they submit a WPCS and/or paramedical authorization letter to DHCS to enter the authorized number of WPCS hours into the CDSS' CMPIS. DHCS notifies the Waiver Agency when the participant's WPCS and/or paramedical service hours are in CMPIS, and then sends timecards to the providers with instructions on how to report the service hours provided to the waiver participant.

WPCS and paramedical service providers submit monthly timesheets signed by the waiver participant or legal representative/legally responsible adult(s), to the County social services' office for review and approval. The timesheets are reconciled with the authorized number of hours in CMIPS and in accordance with the POT. The County Social Services' office authorizes payment for claimed hours of service, documenting the hours worked, the rate of payment, and the gross amount approved for payment. CMIPS generates a payment tape daily that is sent to the State Controller's Office where a payroll warrant is issued to the provider.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

- ☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

In areas where they operate, Waiver Agencies are responsible for prior authorization of all HCBA Waiver services and verification that the requested services are in accordance with the participant's current POT and are medical necessity.

In areas with no Waiver Agency, DHCS is responsible for prior authorization of all HCBA Waiver services, verification that the requested services are in accordance with the participant's current POT, and are medical necessity. HCBA Waiver providers are responsible for direct submission of claims to the FI.

Claims for waiver services must meet either the CA-MMIS or CMIPS requirements for processing, including program edits and audits. Submitted claims are reviewed to verify that all required information is present.

There are several layers of validation to verify that the individual was eligible for Medicaid waiver payment on the date of service, when the service was included in the participant's approved service plan, and the services were provided, before a claim is paid. Payment will only be made for services provided to eligible and enrolled Waiver participants. After enrollment, services must be documented in their POT and must be authorized before the service is provided; therefore, the participant must be eligible on the date of service. DHCS conducts annual QARs to review utilization and verify services were provided in accordance with the primary care physician signed POT. The FI has edits and audits in place to pay only valid claims. DHCS only pays the tiered Comprehensive Case Management rate to Waiver Agencies based on the participant's assessed level of case management acuity.

In areas where there is no Waiver Agency, CA-MMIS pays the HCBA Waiver Case Management rate per the Medi-Cal fee schedule, directly to the provider.

Completed claims processed through CA-MMIS are run against system edits and audits to verify:
• Services are prior authorized;
• Satisfactory Medi-Cal eligibility status;
• Participants are enrolled in the HCBA Waiver;
• Providers are an enrolled Waiver Agency or HCBA Waiver provider;
• Claims are not duplicates;
• Claims are paid per the published rates;
• Participants were not institutionalized during the time covered by the claim; and
• Appropriate HCBA Waiver procedure codes are used.

Completed WPCS claims processed through CMIPS are run against system edits and audits to verify:
• Services are pre-authorized;
• Participants are authorized to receive services through IHSS and enrolled in the HCBA Waiver program;
• Providers are enrolled as a WPCS or paramedical service provider authorized to provide services to the HCBA Waiver participant;
• Claims are not duplicates;
• Claims do not exceed maximum authorized hours; and
• Participants were not institutionalized for more than seven days during the time covered by the claim.

DHCS conducts annual QARs to verify services are provided.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such

payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

CMIPS is the statewide database, managed by CDSS, that is used for case management, payroll, and reports for WPCS and paramedical service reimbursement. CMIPS supports case management and payroll functions for the IHSS program, and HCBA Waiver WPCS and paramedical services. IHSS is not a waiver service.

CMIPS provides the state with a web based case management platform and provides centralized processing of IHSS, WPCS, and paramedical service timesheets for the entire state. These functions support timely data verification, assist with reducing fraud, and allow case management and payroll data to be tracked and monitored using a single platform.

IHSS, WPCS, and paramedical service providers have the option to submit either a paper timesheet or to submit a timesheet via the Electronic Timesheet System (ETS). All paper timesheets are processed at a centralized processing location in Chico, CA. The ETS option allows providers to submit their timesheet online using a tablet, smartphone, laptop, or computer. The ETS system interfaces with CMIPS and providers who utilize ETS are paid in the same manner as providers who utilize paper timesheets. CDSS is responsible for ensuring IHSS, WPCS, and paramedical service providers are paid each month.

Every month, CDSS provides DHCS with a formatted file comprised of WPCS and paramedical utilization data. The file represents all of the claims for WPCS and paramedical services that CDSS paid during the month. The data is loaded into the DHCS data warehouse and assigned a T-MSIS file type when reported. CDSS then invoices the California Department of Health Care (DHCS) for FMAP/FFP funding for IHSS and any cost associated with facilitating WPCS and Waiver paramedical services. DHCS' Accounting Branch enters the FMAP into the quarterly CMS 64 report.

Separately, flat rate payments for HCBA Waiver Comprehensive Care Management services are based on monthly enrollment numbers and participants' assessed case management acuity levels. At the end of each month, DHCS runs an enrollment report in MedCompass to verify the number of enrolled participants served by each Waiver Agency. The report identifies the number of participants at each level of case management acuity and the corresponding payment totals. Staff within ISCD generate monthly invoices based on the MedCompass reports and submit the invoices to DHCS' Accounting Branch for validation and reporting purposes. Upon approval, DHCS' Accounting Branch sends the invoices to the State Controller's Office for checkwrite.

All required enrollment and case management documentation is uploaded and stored in MedCompass for auditing purposes and both DHCS and the State Controller's Office comply with applicable State and Federal fiscal and reporting requirements, which includes the basis for the draw of federal funds and claiming of these expenditures on the CMS-64. Payments made by DHCS to Waiver Agencies for comprehensive care management services are captured by DHCS' Accounting Branch and input in to T-MSIS submissions.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Some Waiver Agencies are local county governments. They receive the same monthly Comprehensive Care Management reimbursement rates for providing Comprehensive Care Management services as is received by all Waiver Agencies providing the same services. The rate does not exceed reasonable costs incurred in furnishing this service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

The Waiver Agency services are procured through the State contracting process that involves a Solicitation for Application (SFA). After the SFA process each agency must obtain a Medi-Cal provider number through the DHCS Provider Enrollment Branch, Payment Systems Division for processing.

Disclosure / Program Integrity

Federal regulations require providers of Medicaid programs to monitor and enforce program integrity by requiring providers to disclose certain information. Medi-Cal satisfies these federal regulations for disclosure and deters fraud and abuse by requiring providers to complete DHCS 6207, the Medi-Cal Disclosure Statement form. The DHCS 6207 is submitted to the Payment Systems Division, DHCS for processing.

Provider Qualifications / Requirements

Waiver Agencies may be local governmental or private nonprofit and for-profit organizations, which are procured through an SFA.

In areas where there is a Waiver Agency, providers are not required to contract with the Waiver Agency. They may provide services as long as they are enrolled in Medi-Cal and determined to be a qualified waiver provider based on the provider qualifications outlined in the Waiver application. If qualified providers choose not to contract with the Waiver Agency, they will receive the HCBA Waiver FFS rate.

Waiver Agencies are responsible for prior authorization of all HCBA Waiver services and verification that the requested services are provided in accordance with the participant's current POT, and are medical necessity.

In areas where there is no Waiver Agency, DHCS is responsible for prior authorization of all HCBA Waiver services and verification that the requested services are in accordance with the participant's current POT and are medical necessity. HCBA Waiver providers are responsible for direct submission of claims to the FI.

Informing New Enrollees

Once an individual is determined to be eligible to enroll in the HCBA Waiver, a qualified care manager describes the HCBA Waiver services, limitations, requirements, and any feasible alternative programs, including the option of being institutionalized. The qualified care manager answers any questions the interested individual/applicant may have.

Enrollment and Selections

In order to enroll in the HCBA Waiver, a completed HCBA application packet must be submitted to DHCS for enrollment review to evaluate the applicant's medical necessity needs and eligibility qualifications.

Waiver Agency Requirements

The State requires Waiver Agencies to have a formal contract in place with DHCS to establish Waiver Agency administrative and comprehensive care management requirements; and that contracted Waiver Agencies obtain a Waiver Provider agreement from each Waiver service provider, before providing services to a participant. All Waiver Provider Agreements are uploaded in MedCompass.

Monitoring of Waiver Agency providers

DHCS performs annual QARs of all Waiver Agencies. During the QARs, DHCS verifies that the amount billed by a Waiver Agency for waiver services is equal to the amount it expends to provide services plus the amount paid to subcontractors / vendors. DHCS reviews policies and procedures, billing reports, vendor invoices, participant files, provider files, staff licensure, etc. DHCS samples vendor claims by comparing invoices billed to the Waiver Agency to POTs and claims for which the Waiver Agency was reimbursed by Medi-Cal. DHCS reviews Waiver Agency's contracting process meets DHCS' requirements, that vendors are

qualified, that appropriate services and amount of services are being billed in accordance with the Waiver Participant's POT, and the appropriate provider is providing these services, during the annual QAR. If DHCS finds that there are discrepancies, an audit of the provider prior to the scheduled, annual audit may occur.

Freedom of Choice of Providers

DHCS maintains an approved waiver provider list from which waiver participants are able to choose providers. Providers not on that list and requested by a participant are required to apply to enroll in Medi-Cal and become a waiver provider to provide Waiver services.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

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

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

Waiver participants residing in a CLHF or an ICF/DD-CN pay the facility directly for the provision of room and board at the beginning of the month, from their SSI/SSP income, retaining the Personal Needs Allowance as governed by regulation. The CLHF and ICF/DD-CN bill the Medi-Cal program for the care they render to the participant at the end of the month, only billing for the days in which the participant was enrolled in the HCBA Waiver.

Appendix I: Financial Accountability

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

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

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

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	53918.48	57650.00	111568.48	130530.00	8437.00	138967.00	27398.52
2	54087.02	57575.00	111662.02	139026.00	8437.00	147463.00	35800.98
3	54179.66	57501.00	111680.66	148111.00	8437.00	156548.00	44867.34
4	54233.00	57426.00	111659.00	157826.00	8437.00	166263.00	54604.00
5	54265.24	57351.00	111616.24	168217.00	8437.00	176654.00	65037.76

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	9871	3257	6515	99
Year 2	10759	3550	7101	108
Year 3	11727	3870	7740	117
Year 4	12782	4218	8436	128
Year 5	13932	4598	9195	139

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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

The state used data from three years of 372 reports (2017 through 2019) to determine the ALOS was 334 days. Although there are minor fluctuations in the ALOS from year to year, it has consistently remained around 330 days for the past 9 years. There was a slight decline in 2019 as Waiver Agencies prioritized reevaluations of Waiver Participants and the elimination of the waitlist stemming from the previous Waiver Term. DHCS anticipates that the ALOS for 2020 will be higher than previous years because of the COVID-19 public health emergency (PHE) and temporary pause on dis-enrollments.

The projected ALOS for each year of the Waiver are included below.

2022 = 334
2023 = 334
2024 = 334
2025 = 334
2026 = 334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The Factor D utilization for existing waiver services are derived from experience as reported in the CMS 372 reports for the HCBA Waiver and estimates for utilization of infrequently used services. The CMS 372 Reports used:

WY 1 (January 1, 2017 – December 31, 2017)
WY 2 (January 1, 2018 - December 31, 2018)
WY 3 (January 1, 2019 - December 31, 2019)
WY 4 (January 1, 2020 – December 31, 2020)

The following are assumption also used in deriving the Factor D:

• The state assumes 99% of the waiver population is served by Waiver Agencies providing Comprehensive Care Management services while the state provides Case Management services to the remaining 1% of the Waiver population.
• The state used net enrollment trends to determine at what point existing waiver capacity would need to be increased to meet the demand for Waiver services.
• Waiver participants under 21 years of age receive Waiver services that are not available through the State Plan.
• The Community Transition Services benefit is capped at a lifetime benefit of $5,000 for individuals transitioning to the community from an institution, and at a lifetime benefit of $400 for individuals who live in a private, community-based, residence where the person is directly responsible for their own living expenses. (Under certain circumstances described in Appendix C, the "lifetime" benefit cap may be waived.)
• The Environmental Accessibility Adaptations benefit is capped at a lifetime benefit of $5,000. (Under certain circumstances described in Appendix C, the "lifetime" benefit cap may be waived.)
• The Medical Equipment Operating Expense is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the participant's place of residence. The minimum monthly amount of reimbursement will be $20 a month with a maximum monthly amount of $75. For purposes of completing Appendix J-d, an average of $52.73 is used based on reported utilization obtained from CMS 372 reports.
• The average reimbursement rate for a waiver service is derived from a weighted average of reimbursement rates for the different providers providing a waiver service.
• DHCS does not anticipate an additional increase in rates. The increase in costs is due to the projected increase in utilization, minimum wage increase, and overtime (WPCS). Cost for care management and based upon full Waiver capacity and 372 data trends from 2017-2020.
• Factor D utilization is based on the maximum number of unduplicated participants that can be served in any given waiver year. While in the past the actual number of unduplicated participants has been less than the maximum number allowed it is DHCS' intention to eventually have HCBA Waiver enrollment at full capacity.
• Factor D utilization for ICF/DD-CN Vent and Non-Vent Dependent LOC is based on the number of participants and their current services at the end of the [previous waiver term as well as the assumption that any remaining slots will be filled during WY 1].
• Factor D cost is based on an average percent of each service utilized in the past five years as found in the CMS 372 report.

The increase in Waiver costs is based on projected increases in Waiver enrollment totals over time. Changes to the cost of Waiver services are made through the State's budget process prior to being incorporated into the Waiver. For this reason, the estimated cost per waiver service remains flat across all five years of the Waiver term. If and when State Budget Authority is authorized to allow for increases to Waiver service costs, the State would engage CMS to amend the HCBA Waiver.
In an effort to promote and streamline enrollment into HCBS Waivers, the State is encouraging linkages between HCBS providers within shared service areas. To this end, DHCS is encouraging Waiver Agencies to work with California Community Transitions (CCT) Lead Organizations to transition eligible residents who wish to enroll in the HCBA Waiver upon transitioning to a community-based setting, for the following reasons:
1. The CCT LOs specialize in transition coordination and person-centered planning.
2. There is dedicated grant funding for CCT Transition Coordination that can pay CCT LOs for the time and resources they invest in an enrollee before they successfully transition from a facility; whereas, HCBA Waiver Agencies provide transition coordination services at their own risk, and are only paid for their time and effort working to transition residents of nursing facilities to the community if the transition is successful and the individual enrolls in the HCBA Waiver.

3. CCT provides a higher maximum threshold for home set-up costs and home modifications for each individual.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor D' estimates for State Plan services are derived from experience as found in the HCBA Waiver CMS 372 Reports for:

WY 1 (January 1, 2017 – December 31, 2017)
WY 2 (January 1, 2018 - December 31, 2018)
WY 3 (January 1, 2019 - December 31, 2019)
WY 4 (January 1, 2020 – December 31, 2020)

The following are assumptions used in deriving the Factor D':

The cost of all State Plan services furnished in addition to waiver services while the participant was on the waiver, including, but not limited to:

• State Plan home health services;
• State Plan personal care services authorized through the county IHSS program;
• EPSDT supplemental services;
• Short-term institutionalization (hospitalization or nursing facility) which began after the participant's first day of waiver services and ended before the end of the waiver year, if the person returned to the waiver;
• Medical equipment and supplies covered under the State Plan;
• Non-emergency transportation services covered under the State Plan; and
• Outpatient clinic and physician services covered under the State plan.
• Factor D' expenditures of individuals at each LOC were weighted into the Factor D' estimates for current HCBA Waiver participants.
• DHCS does not anticipate an additional increase in rates. The increase in costs is due to the projected increase in utilization and overtime (IHSS) and based upon full Waiver capacity and 372 data trends from 2017-2020.
• Medicare Part D drug costs are not included in the Factor D' estimates.
• Factor D' cost is based on a weighted average by levels of care.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G reflects the peer group for participants in this waiver. The Factor G estimates for inpatient NF B, Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DDCN Ventilator Dependent and Acute hospital are derived from the State's daily institutional costs for the same number of days used for Factor D. This establishes an annual cost by level of care.

Factor G estimates are derived from the statewide weighted average calculated rates for LOC for NF B, Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DD-CN Ventilator Dependent and Acute hospital times 334 days a year. This establishes an annual cost by level of care. NF/B LOC is expected to have a yearly rate increase of 6.51%. The calculated percentages of beneficiaries enrolled in each level of care in the waiver is as follows: 66% in NF/B; 33% in NF Subacute Adult and ICF-DD; 1% in Acute Hospital.

DHCS does not anticipate a mid-year rate increase. The annual increase in costs is due to the projected yearly rate increases for institutional provider types.

Factor G cost is based off a weighted average by levels of care.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G' reflects the outpatient services of the peer group for participants in this waiver, while residing in an inpatient NF B, Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DD-CN Ventilator Dependent and Acute hospital stay are based on the weighted average of the HCBA Waiver 372 reports.

The following CMS 372 Reports were used:

WY 1 (January 1, 2017 – December 31, 2017)
WY 2 (January 1, 2018 - December 31, 2018)
WY 3 (January 1, 2019 - December 31, 2019)
WY 4 (January 1, 2020 – December 31, 2020)

DHCS does not anticipate an additional increase in rates. The annual increase in costs is due to the increase in utilization of ancillary or State Plan services.

Medicare Part D drug costs are not included in the Factor G' estimates. Factor G' cost is based off a weighted average by levels of care.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Habilitation Services	
Home Respite	
Waiver Personal Care Services (WPCS)	
Paramedical Service	
Assistive Technology	
Community Transition Services	
Comprehensive Care Management	
Continuous Nursing and Supportive Services	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	
Environmental Accessibility Adaptations	
Facility Respite	
Family/Caregiver Training	
Medical Equipment Operating Expense	
Personal Emergency Response (PERS) Installation and Testing	
Personal Emergency Response Systems (PERS)	
Private Duty Nursing - Including Home Health Aide and Shared Services	
Transitional Case Management	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**632522.88**
Case Management	Quarter Hour	737	64.00	13.41	**632522.88**	
Habilitation Services Total:						**1029644.56**
Habilitation Services	Quarter Hour	73	1246.00	11.32	**1029644.56**	
Home Respite Total:						**103868.25**
Home Respite	Quarter Hour	25	703.00	5.91	**103868.25**	
Waiver Personal Care Services (WPCS) Total:						**179102400.00**
Waiver Personal Care Services Regular Time	Hour	4880	2078.00	16.00	**162250240.00**	
Waiver Personal Care Services Overtime	Hour	4051	520.00	8.00	**16852160.00**	
Paramedical Service Total:						**360992.00**
Paramedical Service	Hour	58	389.00	16.00	**360992.00**	
Assistive Technology Total:						**2500.00**
Assistive Technology	Event	1	1.00	2500.00	**2500.00**	
Community Transition Services Total:						**24599.80**
Community Transition Services	Event	47	1.00	523.40	**24599.80**	
Comprehensive Care Management Total:						**25779600.00**
Comprehensive Care Management	Month	7812	12.00	275.00	**25779600.00**	
Continuous Nursing and Supportive Services Total:						**33465384.96**
Continuous Nursing and Supportive Services	Day	392	224.00	381.12	**33465384.96**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**1490344.80**
Developmentally					**1490344.80**	

GRAND TOTAL:	**532229332.66**
Total Estimated Unduplicated Participants:	**9871**
Factor D (Divide total by number of participants):	**53918.48**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	70	42.00	506.92		
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**180361.86**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	23	14.00	560.13	**180361.86**	
Environmental Accessibility Adaptations Total:						**114857.41**
Environmental Accessibility Adaptations	Event	71	1.00	1617.71	**114857.41**	
Facility Respite Total:						**53865.00**
Facility Respite	Day	19	9.00	315.00	**53865.00**	
Family/Caregiver Training Total:						**8038.80**
Family/Caregiver Training	Hour	6	33.00	40.60	**8038.80**	
Medical Equipment Operating Expense Total:						**19615.56**
Medical Equipment Operating Expense	Month	31	12.00	52.73	**19615.56**	
Personal Emergency Response (PERS) Installation and Testing Total:						**3400.00**
Personal Emergency Response (PERS) Installation and Testing	Event	10	1.00	340.00	**3400.00**	
Personal Emergency Response Systems (PERS) Total:						**1700.16**
Personal Emergency Response Systems (PERS)	Month	7	12.00	20.24	**1700.16**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**289839281.82**
LVN	Hour	2523	2398.00	43.87	**265420255.98**	
RN	Hour	276	892.00	58.37	**14370227.04**	
CHHA					**10048798.80**	

GRAND TOTAL:	**532229332.66**
Total Estimated Unduplicated Participants:	**9871**
Factor D (Divide total by number of participants):	**53918.48**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hour	254	1395.00	28.36		
Transitional Case Management Total:						**16354.80**
Transitional Case Management	Hour	5	72.00	45.43	**16354.80**	

GRAND TOTAL:	**532229332.66**
Total Estimated Unduplicated Participants:	**9871**
Factor D (Divide total by number of participants):	**53918.48**
Average Length of Stay on the Waiver:	334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**683159.04**
Case Management	Quarter Hour	796	64.00	13.41	**683159.04**	
Habilitation Services Total:						**1128377.60**
Habilitation Services	Quarter Hour	80	1246.00	11.32	**1128377.60**	
Home Respite Total:						**112177.71**
Home Respite	Quarter Hour	27	703.00	5.91	**112177.71**	
Waiver Personal Care Services (WPCS) Total:						**195212512.00**
Waiver Personal Care Services Regular Time	Hour	5319	2078.00	16.00	**176846112.00**	
Waiver Personal Care Services Overtime	Hour	4415	520.00	8.00	**18366400.00**	
Paramedical Service Total:						**392112.00**
Paramedical Service	Hour	63	389.00	16.00	**392112.00**	
Assistive Technology Total:						**427500.00**

GRAND TOTAL:	**581922293.12**
Total Estimated Unduplicated Participants:	**10759**
Factor D (Divide total by number of participants):	**54087.02**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	Event	171	1.00	2500.00	427500.00	
Community Transition Services Total:						24599.80
Community Transition Services	Event	47	1.00	523.40	24599.80	
Comprehensive Care Management Total:						29521800.00
Comprehensive Care Management	Month	8946	12.00	275.00	29521800.00	
Continuous Nursing and Supportive Services Total:						36453365.76
Continuous Nursing and Supportive Services	Day	427	224.00	381.12	36453365.76	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						1618088.64
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	76	42.00	506.92	1618088.64	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						196045.50
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	25	14.00	560.13	196045.50	
Environmental Accessibility Adaptations Total:						124563.67
Environmental Accessibility Adaptations	Event	77	1.00	1617.71	124563.67	
Facility Respite Total:						59535.00
Facility Respite	Day	21	9.00	315.00	59535.00	
Family/Caregiver Training Total:						8038.80
Family/Caregiver Training	Hour	6	33.00	40.60	8038.80	
Medical Equipment Operating Expense Total:						23412.12
Medical Equipment Operating Expense	Month				23412.12	

GRAND TOTAL:	581922293.12
Total Estimated Unduplicated Participants:	10759
Factor D (Divide total by number of participants):	54087.02
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		37	12.00	52.73		
Personal Emergency Response (PERS) Installation and Testing Total:						**3740.00**
Personal Emergency Response (PERS) Installation and Testing	Event	11	1.00	340.00	**3740.00**	
Personal Emergency Response Systems (PERS) Total:						**1943.04**
Personal Emergency Response Systems (PERS)	Month	8	12.00	20.24	**1943.04**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**315931322.44**
LVN	Hour	2750	2398.00	43.87	**289300715.00**	
RN	Hour	301	892.00	58.37	**15671878.04**	
CHHA	Hour	277	1395.00	28.36	**10958729.40**	
Transitional Case Management Total:						**0.00**
Transitional Case Management	Hour	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**581922293.12**
Total Estimated Unduplicated Participants:	**10759**
Factor D (Divide total by number of participants):	**54087.02**
Average Length of Stay on the Waiver:	334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**738086.40**
Case Management	Quarter Hour		64.00	13.41	**738086.40**	

GRAND TOTAL:	**635364833.31**
Total Estimated Unduplicated Participants:	**11727**
Factor D (Divide total by number of participants):	**54179.66**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		860				
Habilitation Services Total:						**1227110.64**
Habilitation Services	Quarter Hour	87	1246.00	11.32	**1227110.64**	
Home Respite Total:						**124641.90**
Home Respite	Quarter Hour	30	703.00	5.91	**124641.90**	
Waiver Personal Care Services (WPCS) Total:						**212789824.00**
Waiver Personal Care Services Regular Time	Hour	5798	2078.00	16.00	**192771904.00**	
Waiver Personal Care Services Overtime	Hour	4812	520.00	8.00	**20017920.00**	
Paramedical Service Total:						**423232.00**
Paramedical Service	Hour	68	389.00	16.00	**423232.00**	
Assistive Technology Total:						**462500.00**
Assistive Technology	Event	185	1.00	2500.00	**462500.00**	
Community Transition Services Total:						**24599.80**
Community Transition Services	Event	47	1.00	523.40	**24599.80**	
Comprehensive Care Management Total:						**33267300.00**
Comprehensive Care Management	Month	10081	12.00	275.00	**33267300.00**	
Continuous Nursing and Supportive Services Total:						**39782830.08**
Continuous Nursing and Supportive Services	Day	466	224.00	381.12	**39782830.08**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**1767123.12**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	83	42.00	506.92	**1767123.12**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent						**219570.96**

GRAND TOTAL:	**635364833.31**
Total Estimated Unduplicated Participants:	**11727**
Factor D (Divide total by number of participants):	**54179.66**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:						
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	28	14.00	560.13	**219570.96**	
Environmental Accessibility Adaptations Total:						**137505.35**
Environmental Accessibility Adaptations	Event	85	1.00	1617.71	**137505.35**	
Facility Respite Total:						**65205.00**
Facility Respite	Day	23	9.00	315.00	**65205.00**	
Family/Caregiver Training Total:						**9378.60**
Family/Caregiver Training	Hour	7	33.00	40.60	**9378.60**	
Medical Equipment Operating Expense Total:						**25943.16**
Medical Equipment Operating Expense	Month	41	12.00	52.73	**25943.16**	
Personal Emergency Response (PERS) Installation and Testing Total:						**4080.00**
Personal Emergency Response (PERS) Installation and Testing	Event	12	1.00	340.00	**4080.00**	
Personal Emergency Response Systems (PERS) Total:						**1943.04**
Personal Emergency Response Systems (PERS)	Month	8	12.00	20.24	**1943.04**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**344271062.54**
LVN	Hour	2997	2398.00	43.87	**315285179.22**	
RN	Hour	328	892.00	58.37	**17077661.12**	
CHHA	Hour	301	1395.00	28.36	**11908222.20**	
Transitional Case Management Total:						**22896.72**
Transitional Case Management	Hour	7	72.00	45.43	**22896.72**	

GRAND TOTAL:	**635364833.31**
Total Estimated Unduplicated Participants:	**11727**
Factor D (Divide total by number of participants):	**54179.66**
Average Length of Stay on the Waiver:	334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**797304.96**
Case Management	Quarter Hour	929	64.00	13.41	**797304.96**	
Habilitation Services Total:						**1339948.40**
Habilitation Services	Quarter Hour	95	1246.00	11.32	**1339948.40**	
Home Respite Total:						**137106.09**
Home Respite	Quarter Hour	33	703.00	5.91	**137106.09**	
Waiver Personal Care Services (WPCS) Total:						**231913312.00**
Waiver Personal Care Services Regular Time	Hour	6319	2078.00	16.00	**210094112.00**	
Waiver Personal Care Services Overtime	Hour	5245	520.00	8.00	**21819200.00**	
Paramedical Service Total:						**454352.00**
Paramedical Service	Hour	73	389.00	16.00	**454352.00**	
Assistive Technology Total:						**500000.00**
Assistive Technology	Event	200	1.00	2500.00	**500000.00**	
Community Transition Services Total:						**24599.80**
Community Transition Services	Event	47	1.00	523.40	**24599.80**	
Comprehensive Care Management Total:						**37009500.00**
Comprehensive Care Management	Month	11215	12.00	275.00	**37009500.00**	
Continuous Nursing and Supportive Services Total:						**43283036.16**
Continuous Nursing					**43283036.16**	

GRAND TOTAL:	**693206162.79**
Total Estimated Unduplicated Participants:	**12782**
Factor D (Divide total by number of participants):	**54233.00**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Supportive Services	Day	507	224.00	381.12		
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**1916157.60**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	90	42.00	506.92	**1916157.60**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**235254.60**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	30	14.00	560.13	**235254.60**	
Environmental Accessibility Adaptations Total:						**148829.32**
Environmental Accessibility Adaptations	Event	92	1.00	1617.71	**148829.32**	
Facility Respite Total:						**70875.00**
Facility Respite	Day	25	9.00	315.00	**70875.00**	
Family/Caregiver Training Total:						**10718.40**
Family/Caregiver Training	Hour	8	33.00	40.60	**10718.40**	
Medical Equipment Operating Expense Total:						**30372.48**
Medical Equipment Operating Expense	Month	48	12.00	52.73	**30372.48**	
Personal Emergency Response (PERS) Installation and Testing Total:						**4420.00**
Personal Emergency Response (PERS) Installation and Testing	Event	13	1.00	340.00	**4420.00**	
Personal Emergency Response Systems (PERS) Total:						**2185.92**
Personal Emergency Response Systems (PERS)	Month	9	12.00	20.24	**2185.92**	
Private Duty Nursing -						**375305293.34**

GRAND TOTAL:	**693206162.79**
Total Estimated Unduplicated Participants:	**12782**
Factor D (Divide total by number of participants):	**54233.00**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Including Home Health Aide and Shared Services Total:						
LVN	Hour	3267	2398.00	43.87	**343689249.42**	
RN	Hour	358	892.00	58.37	**18639642.32**	
CHHA	Hour	328	1395.00	28.36	**12976401.60**	
Transitional Case Management Total:						**22896.72**
Transitional Case Management	Hour	7	72.00	45.43	**22896.72**	

GRAND TOTAL:	**693206162.79**
Total Estimated Unduplicated Participants:	**12782**
Factor D (Divide total by number of participants):	**54233.00**
Average Length of Stay on the Waiver:	334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**860814.72**
Case Management	Quarter Hour	1003	64.00	13.41	**860814.72**	
Habilitation Services Total:						**1452786.16**
Habilitation Services	Quarter Hour	103	1246.00	11.32	**1452786.16**	
Home Respite Total:						**149570.28**
Home Respite	Quarter Hour	36	703.00	5.91	**149570.28**	
Waiver Personal Care Services (WPCS) Total:						**252794944.00**
Waiver Personal Care Services Regular Time	Hour	6888	2078.00	16.00	**229012224.00**	
Waiver Personal Care Services					**23782720.00**	

GRAND TOTAL:	**756023281.08**
Total Estimated Unduplicated Participants:	**13932**
Factor D (Divide total by number of participants):	**54265.24**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overtime	Hour	5717	520.00	8.00		
Paramedical Service Total:						**491696.00**
Paramedical Service	Hour	79	389.00	16.00	**491696.00**	
Assistive Technology Total:						**540000.00**
Assistive Technology	Event	216	1.00	2500.00	**540000.00**	
Community Transition Services Total:						**24599.80**
Community Transition Services	Event	47	1.00	523.40	**24599.80**	
Comprehensive Care Management Total:						**40751700.00**
Comprehensive Care Management	Month	12349	12.00	275.00	**40751700.00**	
Continuous Nursing and Supportive Services Total:						**47210096.64**
Continuous Nursing and Supportive Services	Day	553	224.00	381.12	**47210096.64**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**2086482.72**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	98	42.00	506.92	**2086482.72**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**258780.06**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	33	14.00	560.13	**258780.06**	
Environmental Accessibility Adaptations Total:						**161771.00**
Environmental Accessibility Adaptations	Event	100	1.00	1617.71	**161771.00**	
Facility Respite Total:						**76545.00**
Facility Respite	Day	27	9.00	315.00	**76545.00**	

GRAND TOTAL:	**756023281.08**
Total Estimated Unduplicated Participants:	**13932**
Factor D (Divide total by number of participants):	**54265.24**
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family/Caregiver Training Total:						**10718.40**
Family/Caregiver Training	Hour	8	33.00	40.60	**10718.40**	
Medical Equipment Operating Expense Total:						**32270.76**
Medical Equipment Operating Expense	Month	51	12.00	52.73	**32270.76**	
Personal Emergency Response (PERS) Installation and Testing Total:						**4760.00**
Personal Emergency Response (PERS) Installation and Testing	Event	14	1.00	340.00	**4760.00**	
Personal Emergency Response Systems (PERS) Total:						**2428.80**
Personal Emergency Response Systems (PERS)	Month	10	12.00	20.24	**2428.80**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**409087149.06**
LVN	Hour	3561	2398.00	43.87	**374618125.86**	
RN	Hour	390	892.00	58.37	**20305755.60**	
CHHA	Hour	358	1395.00	28.36	**14163267.60**	
Transitional Case Management Total:						**26167.68**
Transitional Case Management	Hour	8	72.00	45.43	**26167.68**	

GRAND TOTAL:	**756023281.08**
Total Estimated Unduplicated Participants:	**13932**
Factor D (Divide total by number of participants):	**54265.24**
Average Length of Stay on the Waiver:	334