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.R05.02

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

01/01/20

Approved Effective Date: 01/01/20
Approved Effective Date of Waiver being Amended: 01/01/17

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:
1. Update Appendix B-3, sub-section f, Selection of Entrants to the Waiver, to modify the Waiver enrollment policy to prioritize eligible individuals under the age of 21 into the Waiver, and to include this population as one that is eligible for reserved waiver slots.
2. Change the number of days an individual must reside in a facility to be eligible for reserve capacity enrollment into the Waiver from ninety (90) to sixty (60) days, to align with other federal and state HCBS programs and assessments.
3. Increase the number of slots that are reserved for eligible populations in the fourth and fifth years of the Waiver term to align with enrollment ratio requirements and projected increases in enrollment.
4. Make minor, non-substantive changes in various parts of the amendment to ensure consistency throughout the document.

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	
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	Section B-3, subsection f. Selection of Entrants to the Waiver
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	
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:

Minor spelling and language corrections in various sections of the Waiver to ensure consistency and/or accuracy.

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.R05.02
Draft ID: CA.016.05.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/17
Approved Effective Date of Waiver being Amended: 01/01/17

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) for 90 consecutive days or greater 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-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 Home and Community-Based Alternatives (HCBA) Waiver, hereafter referred to as the "Waiver," is to provide Medi-Cal members with long-term medical conditions who 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 members from a medical facility to a home or community setting utilizing Waiver services; 2) offer Medi-Cal eligible members who reside in the community but are at risk of being institutionalized within the next 30 days, the option of utilizing Waiver services to develop a home or community setting program that will safely meet their medical care needs; and 3) maintain overall cost neutrality of HCBS when compared to services that would be provided to the same members in an institution.

DHCS is responsible for monitoring the Waiver. Organizationally, DHCS Integrated Systems of Care Division (ISCD) has two regional offices. The Northern and Southern California regional offices are 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 rules, policies, procedures, and information governing the Waiver program.

DHCS' primary model for the administration and operation of the Waiver is through contracted Waiver Agencies. The Waiver Agencies are responsible for local Waiver administration functions and for the delivery of the Comprehensive Care Management Waiver service provided by a Care Management Team (CMT).

Waiver Agency administration functions include: evaluating applicants' eligibility for the Waiver; submitting enrollment applications and supporting documentation to DHCS for approval (which includes the Intake Medical Summary (IMS), Case Management Report (CMR), Plan of Treatment (POT), Menu of Health Services (MOHS), and Informing Notices); 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; billing the DHCS fiscal intermediary (FI); and adjudicating provider claims.

Waiver Agency's will provide Comprehensive Care Management through a CMT comprised of a Registered Nurse (RN) and Master of Social Work (MSW), who are directly employed or contracted by the Waiver Agency. The CMT works with the participant to identify and coordinate State Plan and HCBA Waiver services, and other resources necessary to enable the participant to transition to the community or remain in his or her own home. Only Waiver Agencies are authorized to receive payment for Comprehensive Care Management services. All other Waiver services are authorized by the Waiver Agency and delivered by willing and qualified Medi-Cal HCBS providers within the designated service area. In areas of the state where there are no willing and qualified HCBS providers, the Waiver Agency may provide Waiver services when authorized to do so by the State, and only after they have clearly demonstrated: 1) their organization is the only willing and qualified provider to develop the person-centered service plan and provide direct Waiver services within the service area; and 2) they have developed and implemented thorough conflict of interest provisions to separate service plan development from the direct provision of Waiver services within their organization.

Waiver Agencies provide Comprehensive Care Management Waiver services to assist Waiver participants with the location of appropriate HCB settings, development of a person-centered care plan, identification of available Waiver providers, and continuous management of Waiver and other Medicaid care services. Appropriate HCB settings include the participant's private home and congregate living health facilities (CLHFs).

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 through willing and qualified Medi-Cal providers approved to provide HCBA Waiver services, as outlined for each service in Appendix C.

Waiver participants must have a current POT signed by the participant and/or legal representative, and the participant's current primary care physician or designated physician assistant or nurse practitioner (herein referred to as "participant's current primary care physician"). The POT describes all of the participant's medically necessary Waiver care services, the required frequency of identified services, and the service providers required to ensure his or her health and safety are maintained in a home or community setting. 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.

For those persons meeting the ICF/MR, DD/CNC LOC and who choose to reside in an ICF/DD-CN, the regional center staff will continue to perform an initial screening for Waiver participation and DHCS will carry out LOC determinations and

redeterminations.

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:

On August 12, 2019, an open invitation was posted on the HCBA website (https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx .) and Public Registrar to allow all waiver participants, advocates, providers of waiver services, and any other interested party, to provide public comment on an amendment to the HCBA Waiver. An invitation was also e-mailed to all active providers, stakeholders, and legislative staff inviting them to submit any questions or comments directly to DHCS via the main HCBA inbox, HCBAlternatives@dhcs.ca.gov. DHCS also provided an option for members of the public to submit comments by mail. The public input period ended on September 10, 2019.
DHCS received a total of 29 responses from 23 entities on the amendment application during the 30-day public comment period.

Below is a breakdown of comments that were received:
- 24% from advocates
- 69% from providers
- 7% from members of the public

Relevant feedback:
A small portion of the comments received were directly related to the purpose of the amendment:
- Reserve Capacity
  - o There was overall support for identifying persons under age 21 as a reserve waiver capacity population.
  - o Some advocates suggested that other populations should also be considered for prioritized enrollment, including: individuals at the subacute level of care, those at immediate risk of institutionalization, and individuals transitioning from other HCBS programs.
- Length of stay in facility
  - o Stakeholders expressed support for reducing the required length of time in facility to qualify for reserve capacity to 60 days, however they suggested that this requirement be further reduced to 30 days.
    DHCS Response: The change to the 60-day requirement for an institutional stay puts the HCBA Waiver in alignment with other HCBS program standards.
- Increased Waiver Slots
  - o There was overall support for increasing the number of waiver slots reserved for eligible populations

Other feedback:
The vast majority of comments received were related to other concerns, such as provider types and improvements to the intake process:
- 69% of the comments received were from providers and advocacy groups supporting the position of the Occupational Therapy Association of California (OTAC) that Occupational Therapists should be added as a licensed provider type for all waiver services.
  - o DHCS Response: Occupational Therapists play an important role in providing care to many HCBA Waiver participants. DHCS will take this suggestion into consideration for a future waiver amendment.
- Advocates expressed concerns that the length of time for an individual to be enrolled in the waiver varies in different areas of the state.
  - o DHCS Response: All Waiver Agencies are currently working to process their existing waitlists, which will result in reduced wait times for new applicants. DHCS provides ongoing technical assistance and training to strive for consistency of the program administration throughout the state, and conducts monitoring and oversight to that end.

DHCS did not make changes to the amendment application in response to public comments. Along with the input obtained through the public comment process, DHCS receives ongoing public input regarding the waiver and upcoming changes from waiver participants, their families and other stakeholders.

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: Joseph

First Name: Billingsley

Title: Integrated Systems of Care, Program Policy and Operations Branch 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) 713-8389 **Ext:** **TTY**

Fax: (916) 552-9660

E-mail: Joseph.Billingsley@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: MARI CANTWELL

State Medicaid Director or Designee

Submission Date: Dec 10, 2019

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

Last Name: Cantwell

First Name: Mari

Title: State Medicaid Director

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue, Ste. 6000

Address 2: PO Box 977413, MS 0000

City: Sacramento

State: **California**

Zip: 95899-7413

Phone:

(916) 449-7400 **Ext:** **TTY**

Fax:

(916) 440-7404

E-mail:

mari.cantwell@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 amendment and renewal will be subject to any provisions or requirements included in the state’s most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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.:*

DHCS contracts with Waiver Agencies to administer the 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 purchase Waiver Services through local vendors, enroll participants, perform initial and annual LOC evaluations, review participant care plans, authorize waiver services prior to utilization, develop networks of qualified providers, execute provider agreements, preform quality assurance and reporting for submission to DCHS, bill the DHCS FI, and adjudicate provider claims. 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.

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, establishment of rates, and rules, and policies governing the Waiver.

The Waiver Agency will be able to purchase the following services through subcontracts with local vendors:
o Habilitation Services
o Waiver Personal Care Services (WPCS)
o Community Transitions Services
o Continuous Nursing and Supportive Services
o Developmentally Disabled/Continuous Nursing Care, Non-Ventilator Dependent Services
o Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services
o Family/Caregiver Training
o Personal Emergency Response Installation and Testing
o Personal Emergency Response System
o Private Duty Nursing
o Transitional Case Management

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 public agencies to perform waiver operational and administrative activities/functions, 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.

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, 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.

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 24 months through onsite Quality Assurance Reviews (QAR) to ensure 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 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.

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 Corrective Action Plan (CAP) to address any deficiencies. Upon initial approval of the CAP, DHCS monitors the Waiver Agencies' resolution process to ensure complete remediation of the deficiency(ies). DHCS 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 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	Contracted Entity	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			
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:
#/% of executed contracts between the Medicaid agency and local/regional non-state agencies. Numerator - Number of executed contracts/Denominator - Number of request for application documents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Executed contracts and Request for Applications

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.

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 corrective action plans, make revisions to policies and procedures when necessary, and conduct individual, case-by-case, follow-up, with the Waiver Agencies on specific issues to assure 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 served and document compliance with assurances provided in the HCBA Waiver.

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**
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 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		
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 members who meet the level of care (LOC) for this waiver.

- Consumers shall only be enrolled in one Section1915(c) waiver at any one time.

Acute Hospital LOC General Definition:

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

Subacute LOC General Definition:

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

NF-A/B LOC General Definition:

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

ICF/MR, ICF/DD-CN Definition:

Pursuant to Health and Safety Code Section 1250(m), waiver-designated criteria:

This population includes individuals who are medically fragile; developmentally disabled infants, children, and adults residing in developmental centers, subacute facilities, acute care facilities, ICF/DD-Ns and in their home who meet the following ICF/DD-CN criteria and choose to receive services in their home or in a community care setting:

1. Have Medi-Cal eligibility.
2. Be determined by a Regional Center to have a developmental disability as defined by W&I Code section 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 section 2500 if choosing to receive services in a community care facility.
5. Have an HCBA Waiver Freedom of Choice (FOC) form completed and on file. This form must be completed by the participant or conservator/legal guardian.
6. Meet the following medical necessity criteria:

A. Participant's condition has stabilized to the point that acute care is not medically necessary;
B. Participant's condition warrants the continuous availability of nursing care by a licensed nurse inclusive of nursing assessment, and interventions with documented outcomes; and,
C. Any one of the following:
i. A tracheostomy with dependence on mechanical ventilator not inclusive of CPAP or BiPAP, for the majority of the respiratory effort;
ii. A tracheostomy that requires frequent and/or PRN nursing interventions such as medication administration, suctioning, cleaning inner cannula, changing tracheostomy ties or tube care;
iii. Peritoneal dialysis;
iv. Treatment for pressure sores at stage three or greater, and other wounds requiring sterile technique;
v. Ongoing treatment for multiple health conditions, degenerative disorders, or other complex medical problems requiring skilled nursing observation, assessment and intervention to prevent acute hospital admissions, or as an alternative to the specific conditions identified in this subsection. C. i. – v.

D. Administration of at least two treatment procedures listed below:
i. Nasal-tracheal or oral-tracheal suctioning at least every eight hours and room-air mist or oxygen any part of the day;
ii. Tube feeding either continuous drip or bolus every shift;
iii. Five days per week of physical, speech or occupational therapy provided directly by or under the direct supervision of a licensed therapist, funded by the facility at no additional cost to the Medi-Cal program;
iv. Continuous or daily intravenous administration of therapeutic agents, hydration or total parenteral nutrition (TPN) via a peripheral or a central line;
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	6050
Year 2	7150
Year 3	8250
Year 4	

Waiver Year	Unduplicated Number of Participants
	9350
Year 5	9871

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	5500
Year 2	6500
Year 3	7500
Year 4	8500
Year 5	8974

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:
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	600
Year 2	600
Year 3	600
Year 4	1200
Year 5	1800

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:

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). 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 to ensure they have, and/or maintain, access to medically necessary services in the community setting of their choice.

Waiver applicants who do not meet reserve capacity eligibility requirements 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 his or her eligibility, or disenrolls 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:
i. Individuals transitioning to the Waiver from similar HCBS programs.
ii. Individuals under 21 years of age.
iii. 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 .
iv. 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 ensure the state does not exceed 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. DHCS works closely with CCT, a program developed to assist Medi-Cal eligible individuals that have been residing in a nursing facility, subacute care facility, acute hospital, or an intermediate care facility for persons with developmental disabilities who have resided in a facility for at least three 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 he or

she 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 identify a Waiver service provider and provide DHCS with a primary care physician-signed POT that meets the requirements outlined in Appendix D. If a primary care physician-signed POT is not received within 90 days, a NOA will be sent to the individual and he or she will be removed from the waitlist and their case will be closed. 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 individual must continue to actively work with a county eligibility worker and failure to cooperate with the county will be a valid reason to close the pending Waiver case.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

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

No

Yes

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

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

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

SSI recipients

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

Optional state supplement recipients

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

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

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

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in

§1902(a)(10)(A)(ii)(XV) of the Act)

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

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

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

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

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

Specify:

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

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

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

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

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

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

Other
Specify:

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

An RN, licensed to practice in the State of California, will perform the initial LOC evaluation of the HCBA Waiver applicants during a face-to-face intake home/community visit.

The Waiver Agency will perform the initial review of the LOC evaluation based upon the Case Report. DHCS will review and make the final determination on the LOC evaluation that has been completed by the RN during the initial evaluation. In areas where there is no Waiver Agency, DHCS will continue to perform the LOC evaluations and approve waiver services.

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

The criteria used for waiver LOC is determined by criteria established in Title 22, California Code of Regulations (CCR) Division 3, Sections (§)51173.1, 51120, 51124, 51124.5, 51125.6, 51334 and 51335; Health and Safety Code Section 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 (W&I) 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 W&I Code, Section (§)14059.5, require services only available in an acute hospital setting for at least 90 consecutive days, pursuant to CCR, Title 22, §51173.1 and meet the criteria as described in CCR, Title 22, § 51344 (a) and (b). Waiver Participants at the acute LOC must currently be receiving medically necessary acute LOC services, and choose to remain home, or to return home, to receive medically necessary acute LOC services as a participant enrolled in the Waiver, in lieu of remaining in, or being admitted to the acute hospital setting. All requests for acute hospital LOC Waiver services shall meet the criteria as described in this waiver in addition to the criteria set forth in Title 22, CCR, §51344 (a) (b) (c) and 51173.1.

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

Subacute LOC

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

NF A/B LOC

This Waiver will serve Medi-Cal members who would, in the absence of this Waiver, and as a matter of medical necessity, pursuant to W&I Code, §14059.5, otherwise require care for 60 consecutive days or greater in an inpatient NF providing the following types of care:

1. NF Level A – Intermediate Care services pursuant to Title 22, CCR, §51120 and 51334.
2. NF Level B – Skilled Nursing Facility services pursuant to Title 22, CCR, §51124 and 51335.

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

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

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

DHCS will review all completed applications to verify an applicant's eligibility. A complete application includes a LOC evaluation completed by the Waiver Agency. DHCS will review the LOC evaluation 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 ensure questions are addressed, clarifications are made, and the appropriate LOC is assigned.

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 are determined to be eligible for the waiver.

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:

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

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

When assessing LOC, the Waiver Agency or DHCS reviews the available medical documentation and other pertinent information in the applicant's record (such as the POT, 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.

1. The Waiver Agency or DHCS schedules a face-to-face intake visit with the potential waiver participant and an evaluation is completed. The Waiver Agency or DHCS utilizes this evaluation to determine if the applicant meets one of the HCBA Waiver LOCs. The information from the initial visit is documented in the Case Record along with medical justification to support the LOC and the need to receive the type, frequency, and amount of services that are currently authorized or being requested by the applicant's current primary care physician to ensure the health and safety of the applicant to return and/or remain safely in his or her home and community. The Waiver Agency or DHCS documents the type, frequency, and amount of waiver and State Plan services the applicant is currently receiving or the applicant's current primary care physician has ordered and details it in the Menu of Health Services (MOHS).
2. 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 his or her 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 his or her legal representative/legally responsible adult and/or circle of support, and the applicant's current primary care physician in identifying the State Plan and HCBA Waiver services that meet the applicant's medically necessary care needs.
3. The type, frequency, and amount of the applicant's identified waiver and State plan services are documented in the MOHS worksheet and provided to the applicant and/or his or her legal representative/legally responsible adult prior to enrolling in the HCBA Waiver. The MOHS is a planning instrument used by the applicant and/or his or her legal representative/legally responsible adult, circle of support, and the CMT or HCBA Case Management provider to develop a home care program and ensures 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 his or her legal representative/legally responsible adult and/or his/her circle of support to select a combination of waiver and State Plan services best suited to meet his/her medically necessary care needs and ensure his or her health and safety in the community.
4. The Waiver Agency submits the completed HCBA Waiver application, Medi-Cal eligibility summary report, IMS/CMR and MOHS, also known as the Case Record, to DHCS for approval of waiver enrollment. If DHCS determines the applicant does not meet the medical or health and safety eligibility criteria DHCS will issue a NOA denying enrollment in the HCBA Waiver.
5. Upon DHCS approval of an applicant's enrollment into the Waiver, the Waiver Agency notifies the participant and authorizes the identified medically necessary Waiver services at the type, scope, frequency, and amount described in the approved MOHS.

The Waiver Agency or DHCS conducts a complete LOC evaluation/reevaluation of the applicant or participant's medical need for Waiver services. The initial evaluation and reevaluations for LOC are documented in the Case Record. The evaluation and reevaluations 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 level of services requested.

For a complete description of the LOC criterion used to evaluate and reevaluate an applicant or participant's need for waiver services, refer to Appendix B Section 1.b. Once the evaluation visit is completed, the Waiver Agency and DHCS use the CMR to document the individual's LOC and medically necessary care needs, including identification of

caregivers and support systems; a home safety evaluation and concerns or issues identified by the applicant or participant, his or her 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. 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 Care Management Acuity System 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 documented in the CMR and is used 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 for waiver services. The CMT or HCBA Case Management provider 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 ensuring 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 ensure the overall wellbeing of the Waiver participant, ensure they are receiving the appropriate services in the frequency and duration listed in their POT, they are happy with the services they are receiving, and to address any problems or concerns they may have.

Reevaluation visits are intended to reassess the participant's LOC needs and medically necessary services. All completed reevaluation documentation must be sent to DHCS within the appropriate time frames. Reevaluation period requirements are as follows:

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

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

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

Level 4 - Participants are reevaluated more frequently than once every 180 days. Participants require frequent monitoring and interventions by the CMT or HCBA Case Management provider to address issues that affect their health and safety and are at an elevated risk. The CMT or HCBA Case Management provider conducts frequent on-site visits to work with the participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support and the HCB 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. QARs are conducted by DHCS. DHCS analyzes case records, progress notes, assessment/reassessments, the Participant's POT and any other documentation pertinent to determining:

1. There is documentation supporting the LOC criteria,
2. Evaluations and reevaluations are timely,
3. Documentation has been completed by the appropriate Waiver Agency personnel.

If DHCS identifies deficiencies in LOC reevaluations, DHCS issues a written report of the findings and recommendations to the Waiver Agency, including a formal written request for a Corrective Action Plan (CAP) specific to remediating the deficiencies. The Waiver Agency is required to respond to DHCS within 30 days of the date of the QAR report, and to develop a formal CAP to address any deficiencies that were identified. Upon receipt of the CAP, DHCS monitors the Waiver Agency's resolution process to ensure complete remediation of the deficiency(ies). Once DHCS reviews and approves the CAP for implementation, the Waiver Agency is given an opportunity to implement the developed strategy. Once adequate time for implementation has occurred, 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 request submission of records for additional review by
DHCS. DHCS will issue an approval letter once it is verified that the Waiver Agency has appropriately remediated the issues addressed in the CAP. 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 for workload planning and scheduling of home visits to ensure the timeliness of the reevaluation 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 case record file or in electronically retrievable participant files with the Waiver Agency.

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:
Percent of HCBA Waiver participants who received a LOC evaluation prior to enrollment. Numerator: Number of participants who received a LOC evaluation prior to enrollment / Denominator: Total number of applicants who should have received a LOC evaluation.

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:	**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:
Percent of Waiver participant's LOC determinations that were completed by qualified personnel, RN, with a current license to practice in the State of California and whose qualifications to perform LOC assessments has been validated by specific training based on waiver criteria. Numerator: Number of LOC determinations completed by qualified personnel / Denominator: Total 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:	**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:
Percent of Waiver participant's LOC re/determinations that are completed accurately by qualified LOC evaluators and are based on waiver criteria as found in Title 22 and supported by appropriate medical documentation. Numerator: Number of LOC re/determinations completed accurately in accordance with waiver criteria, Title 22 and 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:	**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 utilizes CMIS, MedCompass, and the QAR, which include case and provider record reviews to monitor the timeliness and accuracy of the initial and reevaluated LOC determinations.

CMIS and subsequently MedCompass capture the data documenting:
- The Waiver Agency or DHCS received HCBA Waiver application;
- The Waiver Agency or DHCS reviewed HCBA Waiver application;
- Receipt of an applicant's evaluation prior to enrollment in the HCBA Waiver;
- Enrollment of an applicant in the HCBA Waiver; and
- The next re-evaluation visit due date, based upon the level of case management acuity.

The QAR conducted by DHCS evaluates the accuracy of the LOC determination based on the information documented in the participant's case report.

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 MSW, as applicable. 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 confirms LOC. CMIS and subsequently MedCompass include an edit that will not allow the participant to be opened to the waiver unless the date of the evaluation visit has been entered. Enrolled status into the waiver is documented by entering the date the participant was approved eligible for the HCBA Waiver.

Re-evaluations of LOC determinations are conducted as described in Appendix B. The Waiver Agency or DHCS is responsible for the timeliness of LOC re-evaluations. DHCS uses CMIS and subsequently MedCompass to discover the timeliness of the reevaluation LOC determination using the Home Visit Over-Due Report. The report calculates the date of the next LOC re-evaluation 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 to DHCS that identifies participants who have not had their LOC re- evaluation completed within 60 days, and their plan or schedule for completing the overdue home visits.

DHCS is responsible for conducting biennial onsite Waiver Agency QAR and, in areas where there is no Waiver Agency, DHCS clinical reviews which will consist of 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 form to document their observations, actions and information obtained during the participant's initial and all re-evaluation visits. The Waiver Agency documents the participant's medically necessary care needs and the justification of the LOC in the CMR and submits to DHCS. DHCS uses the CMR criteria and regulations cited in the HCBA Waiver to verify LOC determinations.

Once DHCS has determined the CMR is complete and agrees with the LOC determination, DHCS signs and dates the case report. 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.

The QAR is used to discover a Waiver Agency's level of compliance with completing the CMR and reviews the LOC determinations to determine if they are in compliance with the HCBA Waiver. 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, remediation actions will be developed and implemented within 30 days by the Waiver Agency. Remediation actions 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, to determine the effectiveness of the remediation actions.

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 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 the right to accept or decline Waiver enrollment and Waiver services during the initial evaluation in the HCBA Waiver.
Information is provided verbally and in writing through use of the FOC and “Informing Notice”.

A signed FOC form is required of all participants at the onset of 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 his or her legal representative/legally responsible adult(s) a FOC letter and form for their signature. The participant’s, and/or his or her legal representative/legally responsible adult(s)’, signature is acknowledgment 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 his or her legal representative/legally responsible adult(s) of his or her 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, his or her 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-sent whenever there is a change in the Waiver Agency, or the participant’s current primary care physician.

The participant and/or his or her 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 file at the designated Waiver Agency or DHCS office.

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):

The following is representative of the Department:

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 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 that are representative of the demographic characteristics of the service area.
- Waiver Agencies ensure that participants receive, from all staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices and preferred language.
- DHCS requires Waiver Agencies to provide linguistic diversity in service providers 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 ensure forms are translated as requested.

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)**		
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**		
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 needed services, regardless of the funding source, to ensure the participant's health and safety and support of his or her home and community-based program. HCBA Case Management providers also assist in acquiring personal care providers as described in the participant's plan of care.

HCBA Case Management providers work with the participant, his or her legal representative/legally responsible adult and/or circle of support, and primary care physician in developing goals and identifying a course of action to respond to the assessed needs of the individual, and in the development and updating of the participant's primary care physician-signed POT. HCBA Case Management providers assist the participant in understanding the various services he or she is receiving or may receive and the impact, if any, of the services received/requested, based on the source of funding, as well as oversee the implementation of the services described in the POT, and evaluate the effectiveness of those services. HCBA Case Management provider responsibilities include assessing, care planning, assisting with locating, coordinating, and monitoring services for community-based participants on the waiver. HCB Alternative Case Management provider services do not include the direct delivery of any other service.

HCBA Waiver RN providers providing Case Management services also supervise, monitor, and train HCBA Waiver LVN providers of private duty nursing services. Waiver participants may select Family/Caregiver Training services for monitoring and training his or her Waiver Personal Care Service (WPCS) and In Home Support Service (IHSS) providers as well as family and back-up caregivers. WPCS and IHSS providers are individuals employed directly by the waiver participant receiving WPCS or IHSS services.

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

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.

This waiver service is only authorized for individuals age 21 and over. All medically necessary Case Management 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
Individual	HCBS Benefit Provider - Licensed Psychologist
Agency	Professional Corporation
Individual	HCBS Benefit Provider - Marriage and Family Therapist (MFT)
Individual	HCBS Waiver Nurse Provider - RN
Agency	Home Health Agency (HHA)
Individual	HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)

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 Section 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 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 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 1000 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 ensure the waiver participant's medical care needs are addressed. 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 medically necessary and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or his or her legal representative/legally responsible adult(s) participated in the development of the POT and was informed of his or her 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 his or 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Biennially

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 Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide Case Management services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:
1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

a. The Licensed Psychologist must provide DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver Case Management services as described on the participant's POT as approved by DHCS.

4. The Licensed Psychologist 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 their scope of practice:

A. Develop the POT consistent with the assessment of the waiver participant and the orders of care prescribed by the participant's current primary care physician. Collaborate with the waiver participant's current primary care physician in the development of the POT to ensure the waiver participant's medical care needs are addressed. 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. Within the Licensed Psychologist's scope of practice, 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. DHCS will review the POT and supporting documents to determine that the requested waiver services are medically necessary and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or his or her legal representative/legally responsible adult(s) participated in the development of the POT and was informed of his or her free choice to select qualified providers.

b. 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 may only be made with the approval of the participant's current primary care physician, the participant and/or his or her legal representative/legally responsible adult(s). DHCS will not complete enrollment of the participant in the HCBA Waiver or approve requested waiver services until the POT accurately reflects the participant's medically necessary services to safely live in his or her home or community based setting, the providers of those services, any goals for the participant, and identifies and provides for 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 participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

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 would ensure 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 biennial Waiver Agency oversight visits.

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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
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: 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 Case Management services approved under the HCBA Waiver and is enrolled as an HCBA 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 Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

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

Minimum qualification and requirements for a Professional Corporation that 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 Corporations Code section 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 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 Corporations Code section 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. (Corporations Code section 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 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 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 DHCS. The professional corporation must notify the DHCS in writing of any change in licensure status of its licensed employees within 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 DHCS.

6. Provide Case Management services consistent with the participant's medically necessary services to safely live in his or her 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 ensure the waiver participant's medical care needs are addressed. 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 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.

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

b. 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 his or her 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 his or her 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 and/or Waiver Agency

Frequency of Verification:

Biennially

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 Benefit Provider - Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A MFT is an individual who is enrolled to provide Case Management services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a MFT.
Minimum qualifications and requirements for a MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

a. The MFT must provide DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT 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 their scope of practice:

A. Develop the POT consistent with the assessment of the waiver participant and the orders of care prescribed by the participant's current primary care physician. Collaborate with the waiver participant's current primary care physician in the development of the POT to ensure the waiver participant's medical care needs are addressed. 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. Within the MFT's scope of practice, 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 MFT'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. DHCS will review the POT and supporting documents to determine that the requested waiver services are medically necessary and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or his or her legal representative/legally responsible adult(s) participated in the development of the POT and was informed of his or her free choice to select qualified providers.

b. 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 may only be made with the approval of the participant's current primary care physician, the participant and/or his or her legal representative/legally responsible adult(s). DHCS will not complete enrollment of the participant in the HCBA Waiver or approve requested waiver services until the POT accurately reflects the participant's medically necessary services to safely live in his or her home or community based setting, the providers of those services, any goals for the participant, and identifies and provides for 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 participant's current primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
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: 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, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

1.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 HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in his or her home or place of residence by and HCBA Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the task as prescribed on the POT. This evaluation would need to be documented and provided to DHCS as indicated.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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 or Waiver Agency. DHCS may require additional documentation to support requests of this nature. Documentation required before 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:

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 5 business days of change.

B. Current Basic Life Support (BLS) certification.

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

a. A minimum of 1000 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 2000 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 2000 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 2000 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 HCBA 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 medically necessary care need(s) to safely live in his or her home or 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. The area where the waiver participant will be cared for 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. This should include a diagram of the participant's home.

b. Primary and back-up 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 back-up 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 evaluation 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.

HCBA Waiver RN acting as the supervisor for a HCBA Waiver LVN shall additionally provide:

1. Written evidence, in a format acceptable to DHCS, of training or experience providing Case Management and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.

2. Written summary, in a format acceptable to DHCS, of nursing care tasks that have been delegated to the LVN.

3. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the waiver participant.

4. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant.

5. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

6. Any change in the nursing care tasks delegated to the LVN and evaluation of the Case Management activities provided.

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: Case Management

Provider Category:
Agency
Provider Type:

Home Health Agency (HHA)
Provider Qualifications
License *(specify):*

HHA CCR Title 22 §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4
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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Individual
Provider Type:

HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)
Provider Qualifications
License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A LCSW is an individual who is enrolled to provide Case Management services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a LCSW.
Minimum qualifications and requirements for a LCSW functioning as an HCBA Waiver Service Provider are:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California, and notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing Case Management services to the elderly and/or persons with disabilities living in the community. The LCSW must provide DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The LCSW 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 their scope of practice:

A. Develop the POT consistent with the assessment of the waiver participant and the orders of care prescribed by the participant's current primary care physician. Collaborate with the waiver participant's current primary care physician in the development of the POT to ensure the waiver participant's medical care needs are addressed. 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. Within the LCSW's scope of practice, 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 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 LCSW'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. DHCS will review the POT and supporting documents to determine that the requested waiver services are medically necessary and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or his or her legal representative/legally responsible adult(s) participated in the development of the POT and was informed of his or her free choice to select qualified providers.

b. 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 may only be made with the approval of the participant's current primary care physician and the participant and/or his or her legal representative/legally responsible adult(s). DHCS will not complete enrollment of the participant in the HCBA Waiver or approve requested waiver services until the POT accurately reflects the participant's medically necessary services to safely live in his or her home or community based setting, the providers of those services, any goals for the participant, and identifies and provides for 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 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:

California Board of Behavioral Sciences
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:

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:**

Habilitation Services are provided in a participant's home or an out-of-home non-facility setting designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment and are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision.

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.

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:

This waiver service is only provided to individuals age 21 and over. All medically necessary Case Management 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	Professional Corporation
Agency	Non-Profit Agency
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Benefit Provider - MFT
Agency	HHA
Individual	HCBS Waiver Nurse Provider - RN
Individual	HCBS Benefit Provider - LCSW

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 services approved under the HCBA Waiver and is enrolled as an HCB 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 section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

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

Minimum qualification and requirements for a Professional Corporation that 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 Corporations Code section 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 Corporations Code section 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. (Corporations Code section 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 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 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 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 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:

DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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 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: Statutory Service
Service Name: Habilitation Services

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has work experience that includes, at least a minimum of 1000 hours of experience in providing services to the elderly and/or persons with disabilities living in the community. The Licensed Psychologist must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver services as described on the participant's POT as approved by the Waiver Agency or DHCS.

A Licensed Psychologist 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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
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 Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A MFT is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a MFT.

Minimum qualifications and requirements for a MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has 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.

a. The MFT must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT must provide Habilitation services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within their scope of practice.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
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):*

HHA Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: 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. “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. “HCB 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 his/her home or place of residence by and HCB Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Individual
Provider Type:

HCBS Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

LCSW
BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A LCSW is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a LCSW.

Minimum qualifications and requirements for a LCSW functioning as an HCBA Waiver Service Provider are:

1. Have and maintains a current, unsuspended, un-revoked license to practice as a LCSW in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have 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.

a. The LCSW must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. A LCSW 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 Behavioral Sciences
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 or regularly scheduled medical and/or non-medical care supervision provided to the participant in his or her own home 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 service provider or family member.

The Home Respite benefit, as authorized, is to temporarily replace non-medical care that was provided to the participant by his or her legal representative/legally responsible adult(s), and/or circle of support 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, the 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, section 2725 et seq.

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 include State Plan services, such as personal care services, adult or pediatric day health care, In-Home Supportive Services (IHSS), PDN, shared PDN, and/or direct care authorized by the participant's private insurance.

Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior in order to safeguard the participant against injury, hazard, or accident.

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, section 2725 et seq.

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	Waiver Personal Care Service (WPCS) Provider
Agency	Non-Profit Agency
Agency	Personal Care Agency
Individual	HCBS Waiver Nurse Provider - RN
Agency	HHA
Agency	Employment Agency
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:

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:

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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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 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: 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 section 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 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 1000 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, section 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, section 51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 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:

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 - 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 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 HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in his or her home or place of residence by an HCBA Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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:

Biennially

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):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: 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 section 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 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 1000 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, section 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, section 51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 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:

Individual

Provider Type:

HCBS Waiver Nurse Provider - LVN

Provider Qualifications

License *(specify):*

BPC §§2859-2873.7
Title 22, §51069;

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBA Waiver Nurse Provider--LVN” means a Licensed Vocational Nurse who provides HCBA 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. “HCBA 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 his or her home or place of residence by an HCBA Waiver LVN, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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
• 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 would ensure 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 biennial Waiver Agency oversight visits.

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 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 or his or her legal guardian, in writing, at least thirty (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 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 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.

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 or his or her legal guardian, in writing, at least thirty (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 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 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:**

Service Definition *(Scope):*

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

HCBA Waiver Standards of Participation

WPCS was established by legislation in 1998 through Assembly Bill (AB) 668 which added Section 14132.97 to the W&I Code. WPCS is designed to assist the waiver participant in gaining independence in his or her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his or her 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 or his or her 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.

W&I Code Section 14132.97 (d)(4) affords an IHSS Public Authority the option of enrolling as a WPCS waiver provider. DHCS works collaboratively with the California Public Authority Association and the California Department of Social Services (DSS) to make this option available. IHSS Public Authorities will be established as a waiver provider through an amendment to this waiver when and if conflict of interest agreements can be reached.

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) so as to ensure the participant's State Plan Personal Care benefit is exhausted prior to receiving WPCS through the HCBA Waiver.

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, section 2725.

The WPCS benefit includes:

• Assistance to Independence in Activities of Daily Living (ADL): Assisting the participant in reaching a self- care goal, the WPCS provider promotes the participant's ability in obtaining and reinforcing his or her highest level of independence in ADLs. The WPCS provider provides assistance and feedback to the participant in an effort to help him or her reach specific self-care goals in performing or directing his or her 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 his or her 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 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 section 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 back to his or her home environment. 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 WIC section 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 but is not limited to: 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 W&I Code section 14132(t) and Title 22, CCR, section 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 W&I Code section 14132(t) and Title 22, CCR, section 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 ensure 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.

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

DHCS will not 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 include State Plan services, such as personal care services, pediatric day health care, IHSS, PDN, shared PDN, and/or direct care authorized by the participant's private insurance. Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior to safeguard the participant against injury, hazard, or accident.

Overtime:
On October 1, 2013, the United States Department of Labor published the Final Rule on applying the Fair Labor Standards Act (FLSA) to domestic service providers, which went into effect on February 1, 2016. FLSA overtime rule requires overtime (time and a half) pay for IHSS and WPCS 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 IHSS and WPCS 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 hours. The waiver participant may be required to select one or more additional providers to ensure sufficient hours of care are provided each day. Each provider must establish a regular workweek schedule for each participant they serve, not to exceed the 70-hours and 45-minutes of IHSS and WPCS 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 the 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 both WPCS & IHSS services.

This waiver service is only authorized for individuals age 21 and over. All medically necessary Case Management 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	WPCS Provider
Agency	Non-Profit Agency
Agency	Personal Care Agency
Agency	HHA
Agency	Employment Agency

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 IHSS and WPCS 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 IHSS and WPCS 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 IHSS and WPCS 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 both WPCS & IHSS services.

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: 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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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 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: 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 section 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 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 1000 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, section 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, section 51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 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:

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:

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

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:

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 section 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 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 1000 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, section 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, section 51204.

7. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 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: 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:**

Service Definition *(Scope):*

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

Community Transition Services are non-recurring set-up expenses 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 and 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. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses;
6. Necessary home accessibility adaptations; and
7. Activities to assess, arrange for, and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary. Documentation must be clearly identified in the POT that these services cannot be obtained from other sources as determined through the POT development process. 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.

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.

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

Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00. The only exception to the $5,000.00 total 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 his or her control. Community Transition Services must be necessary to ensure the health, welfare and safety of the participant, and without which the participant would be unable to move to the private residence and would then require re-institutionalization.

This waiver service is only authorized for individuals age 21 and over. All medically necessary Case Management 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	Professional Corporation
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Benefit Provider - LCSW
Agency	HHA
Individual	HCBS Benefit Provider - MFT
Individual	HCBS Waiver Nurse Provider - RN

Provider Category	Provider Type Title
Agency	Non-Profit Agency

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 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 waiver services to waiver participants under the terms of the HCBA Waiver:

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

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

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

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

Minimum qualification and requirements for a Professional Corporation that 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 Corporations Code section 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 Corporations Code section 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. (Corporations Code section 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 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 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 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 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:

DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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 Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

a. The Licensed Psychologist must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver services as described on the participant's POT as approved by the Waiver Agency or DHCS.

A Licensed Psychologist 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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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 Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A LCSW is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a LCSW.

Minimum qualifications and requirements for a LCSW functioning as an HCBA Waiver Service Provider are:
1. Have and maintains a current, unsuspended, un-revoked license to practice as a LCSW in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have 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.

The LCSW must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. A LCSW 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 Behavioral Sciences
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: Community Transition Services

Provider Category:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A MFT is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a MFT.

Minimum qualifications and requirements for a MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has 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.

a. The MFT must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT must provide Community Transition services consistent with the participant's choice and interests, the primary care physician's orders, and the HCBA Waiver POT, within his or her scope of practice.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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, §§1409-1419.4

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. “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 his or her home or place of residence by and HCB Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 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: 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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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 Generals registry of Charitable Trusts
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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:**

Service Definition *(Scope):*

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

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 coordinating required services from across multiple delivery systems.
Comprehensive Care Management is only provided to HCBA Waiver participants by a qualified CMT comprised of an RN and MSW, who are either 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 his or her own home.

Comprehensive Care Management ensures access to services, regardless of the funding source. 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 tiered acuity level of the participant. Only Waiver Agencies are able to bill for and provide the Comprehensive Care Management waiver service.

The CMT works with the participant, his or her legal representative/legally responsible adult and/or circle of support, and 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.

Comprehensive Care Management services will ensure stabilization and access to Home and Community-Based Services (HCBS). Services will include but are not limited to, 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, 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.
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 direct care services for the waiver participant, while in areas without a Waiver Agency, case management services are concentrated on referring and coordinating services.

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, reassessment and care plan updates.

Comprehensive Care Management also includes the provision of Transitional Case Management and the coordination of any Community Transition services needed. In areas where there is a Waiver Agency, the provision of Transitional Case Management and the coordination of Community Transition services are only available through the CMT.

Comprehensive Care Management is intensive case management as described above. Transitional Case Management supports participants in transitioning from an inpatient setting to a community setting and may include coordinating services such as housing, equipment, supplies or transportation that may be necessary to leave a health care facility. Transitional Case Management services may be provided up to 89 days prior to discharge from a health care facility. Coordination of Community Transition Services is organizing and prioritizing non-recurring set-up expenses 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.

Comprehensive Care Management, Transitional Case Management, and the coordination of Community Transition expenses are included in the flat rate payment received by the Waiver Agency for the provision of Comprehensive Care Management services to each member every month. The rate for Comprehensive Care Management is based on the tiered acuity level of the participant. Actual Community Transition expenses are billable by the CMT as a separate service.

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. Participants may request a review of their service plan at any time.

A Waiver Agency's LOC determination should not differ from a DHCS LOC determination.

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

Comprehensive Care Management services are authorized only where an HCBA Waiver Agency is present and is only provided to HCBA participants by a qualified CMT comprised of an RN and MSW, who are either directly employed or contracted by a Waiver Agency.

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	Home Health Agency (HHA)

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 Section 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 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 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 1000 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 ensure the waiver participant's medical care needs are addressed. 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 medically necessary and that the amount, frequency, duration and provider type of each service is included. The POT must also document that the participant and/or his or her legal representative/legally responsible adult(s) participated in the development of the POT and was informed of his or her 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 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 and/or Waiver Agency

Frequency of Verification:

Biennially

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 Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

d. Registered Nurse (RN) (See Business and Professions Code section 2725, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 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 Corporations Code section 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 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 Corporations Code section 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. (Corporations Code section 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 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 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 DHCS. The professional corporation must notify the DHCS in writing of any change in licensure status of its licensed employees within 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 DHCS.

6. Provide Case Management services consistent with the participant's medically necessary services to safely live in his or her 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 ensure the waiver participant's medical care needs are addressed. 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.

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

b. 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 his or her 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 his or her 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 and/or Waiver Agency

Frequency of Verification:

Biennially

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Comprehensive Care 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, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

1.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. “HCB 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 his or her home or place of residence by and HCB Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

e. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the LVN in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the task as prescribed on the POT. This evaluation needs to be documented and provided to DHCS as indicated.

To ensure 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

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 or Waiver Agency. DHCS may require additional documentation to support requests of this nature. Documentation required before 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:

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 5 business days of change.

B. Current Basic Life Support (BLS) certification.

C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at

least one of the following:

a. A minimum of 1000 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 2000 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 2000 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 2000 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 HCBA 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, as follows:

A. The appropriateness of the nursing assessment and interventions shall be determined by DHCS based upon the waiver participant’s medical condition and medically necessary care need(s) to safely live in his or her home or community based setting.

B. 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.

C. Shall 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.

2. Shall 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. The area where the waiver participant will be cared for 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. This should include a diagram of the participant's home.

B. Primary and back-up 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 back-up 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. Shall 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. Annually, the HCBA Waiver RN provider shall submit the following documentation to DHCS:

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 evaluation 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.

HCBA Waiver RN acting as the supervisor for a HCBA Waiver LVN shall additionally provide:
1. Written evidence, in a format acceptable to DHCS, of training or experience providing Case Management and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.

2. Written summary, in a format acceptable to DHCS, of nursing care tasks that have been delegated to the LVN.

3. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the waiver participant.

4. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant.

5. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

6. Any change in the nursing care tasks delegated to the LVN and evaluation of the Case Management activities provided.

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: Comprehensive Care Management

Provider Category:

Agency

Provider Type:

Home Health Agency (HHA)

Provider Qualifications

License *(specify):*

HHA CCR Title 22 §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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:

Continuous Nursing and Supportive 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:**

Continuous Nursing and Supportive Services (CNSS) are provided to waiver participant's residing in a Congregate Living Health Facility (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, such as meal preparation.

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 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

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.

DHCS will at no time authorize direct care services or any combination of direct care services exceeding 24 hours of care per day under this waiver. Direct care is hands on care to support the care needs of the waiver participant.

This waiver service is only authorized for individuals age 21 and over. All medically necessary Case Management 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	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 sections 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, sections 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, sections 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 ensure the health and safety of the Waiver participant, the physical plant of the CLHF shall conform to the H&S Code section 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 H&S Code section 1267.13(o)(2)(B) and (o)(2)(C), a CLHF shall provide nursing services provided by an RN, LVN, and an 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 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. An 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 H&S Code sections 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

H&S Code section 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 H&S Code section 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 his or her 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 H&S Code section 1267.13(o)(5), the CLHF shall ensure 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.

H&S Code section 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 H&S Code section 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 his or her 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 H&S Code section 1267.13(o)(5), the CLHF shall ensure 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:

Biennially

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.

An ICF/DD-CN Providing DD/CNC Non-Ventilator Dependent Waiver Services:

1. 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 B&P 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. An LVN may render services under the supervision of an RN when the RN is not physically present, within his or her scope of practice (B&P Code section 2725).

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, but is not limited to all of the following:

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.

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. An LVN can render services under the supervision of an RN when the RN is not physically present, pursuant to California Business and Professions (B&P) Code section 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:

A. Assistance with ADLs and instrumental ADLs (IADLs)
B. Ventilator, tracheostomy and respiratory care
C. IV therapy
D. Feeding and elimination care (including tubes)
E. Medication administration
F. Skin care

This waiver service is only authorized for individuals age 21 and over. All medically necessary Case Management 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 H&S Code sections 1250(e) and (h), 1265 et.al., 1266 et.al. and1268.6; and California Code of Regulations (CCR), Title 22, Division 5, Chapter 8, Article 2; and shall provide skilled nursing waiver services in accordance with the CCR, Title 22, sections 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 H&S Code section 1250(m), and CCR, Title 22, sections 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 ensure 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 section 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 sections 483.75(m) and 483.470(h); H&S Code section 1336.3(b); CCR, Title 22, section 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 ensure 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 ensure all facility staff receive training regarding services appropriate for each waiver participant based upon the participant's care needs. 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 ensure the appropriate care of residents and to ensure their health and safety.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification Division

Frequency of Verification:

Bi-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:**

Service Definition *(Scope):*

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

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.

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. An LVN may render services under the supervision of an RN when the RN is not physically present, within his or her scope of practice (B&P Code section 2725).

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, but is not limited to all of the following:

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.

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 B&P Code section 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

This waiver service is only authorized for individuals age 21 and over. All medically necessary Case Management 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 H&S Code sections 1250(e) and (h), 1265 et.al., 1266 et.al. and1268.6; and California Code of Regulations (CCR), Title 22, Division 5, Chapter 8, Article 2; and shall provide skilled nursing waiver services in accordance with the CCR, Title 22, sections 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 H&S Code section 1250(m), the CCR, Title 22, sections 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 ensure 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 section 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 sections 483.75(m) and 483.470(h); H&S Code section 1336.3(b); CCR, Title 22, section 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 ensure 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 ensure all facility staff receive training regarding services appropriate for each waiver participant based upon the participant's care needs. 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 ensure the appropriate care of residents and

to ensure their health and safety.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification Division

Frequency of Verification:

Biennially

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 ensure 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.

Environmental Accessibility Adaptation services are payable up to a total lifetime maximum amount of $5,000.00. The only exceptions to the $5,000.00 total maximum are if:

1. The recipient's place of residence changes or the waiver participant's condition has changed so significantly that additional modifications are necessary to ensure 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.

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 $5,000.00. The only exceptions to the $5,000.00 total maximum are if:

1. The recipient's place of residence changes or the waiver participant's condition has changed so significantly that additional modifications are necessary to ensure 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.

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 Benefit Provider - LCSW
Individual	HCBS Benefit Provider - MFT
Agency	Non-Profit Agency
Agency	Professional Corporation
Agency	HHA
Agency	Durable Medical Equipment (DME) Provider
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Waiver Nurse Provider - RN

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 Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An LCSW is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a LCSW.

Minimum qualifications and requirements for a LCSW functioning as an HCBA Waiver Service Provider are:

1. Have and maintains a current, unsuspended, un-revoked license to practice as a LCSW in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have 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.

The LCSW must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. A LCSW must provide Environmental Accessibility Adaptations 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 Behavioral Sciences
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 Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An MFT is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a MFT.

Minimum qualifications and requirements for an MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has 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.

a. The MFT must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT must provide Environmental Accessibility Adaptation services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within their scope of practice.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
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:

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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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 services approved under the HCBA Waiver and is enrolled as an HCBA 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 section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

d. Registered Nurse (RN) (See Business and Professions Code section 2725, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 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 Corporations Code section 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 Corporations Code section 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. (Corporations Code section 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 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 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 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 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:

DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: 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, Food and Drug Branch

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 Benefit Provider - Licensed Psychologist

Provider Qualifications
License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

a. The Licensed Psychologist must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver services as described on the participant's POT as approved by the Waiver Agency or DHCS.

A Licensed Psychologist 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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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, §§1409-1419.4

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 HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in his or her home or place of residence by and HCBA Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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:

Biennially

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:**

Service Definition *(Scope):*

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

The Facility Respite benefit services are provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence 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 service provider or family member.

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	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:

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 H&S Code sections 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, sections 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, sections 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 ensure the health and safety of the Waiver participant, the physical plant of the CLHF shall conform to the H&S Code section 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 B&P 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 H&S Code section 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 H&S Code sections 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

H&S Code section 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 H&S Code section 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 his or her 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, section 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 H&S Code section 1267.13(o)(5), the CLHF shall ensure 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. 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:

Biennially

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 other members of the participant's circle of support are unpaid, back-up 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 included in the participant's current primary care physician signed POT.

Unlicensed caregivers (WPCS and IHSS) should be evaluated to determine specific training needs that will meet the participant's unique needs and the 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.

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 medically necessary Case Management 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):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: 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, §§1409-1419.4

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 HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by and HCB Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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:

Biennially

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 utility 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.

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 limited to utility costs directly attributed to operation of life sustaining medical equipment in the participant's place of residence and only 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	HHA
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Benefit Provider - MFT
Individual	HCBS Waiver Nurse Provider - RN
Individual	HCBS Benefit Provider - LCSW
Agency	Professional Corporation
Agency	Non-Profit Agency

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):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Individual
Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications
License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

a. The Licensed Psychologist must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver services as described on the participant's POT as approved by the Waiver Agency or DHCS.

A Licensed Psychologist must provide Medical Equipment Operation 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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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 Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A MFT is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a MFT.

Minimum qualifications and requirements for a MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has 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.

a. The MFT must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT must provide Medical Equipment Operating Expense services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within their scope of practice.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
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, §§1409-1419.4

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 HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in his or her home or place of residence by an HCBA Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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, HCBA 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 1000 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 2000 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 2000 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 2000 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, HCBA 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:

Biennially

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 Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A LCSW is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a LCSW.

Minimum qualifications and requirements for a LCSW functioning as an HCBA Waiver Service Provider are:

1. Have and maintains a current, unsuspended, un-revoked license to practice as a LCSW in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have 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.

a. The LCSW must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. A LCSW 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 Behavioral Sciences
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:

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 services approved under the HCBA Waiver and is enrolled as an HCB 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 section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

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

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

1. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 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 Corporations Code section 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. (Corporations Code section 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 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 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 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 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:

DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 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 1000 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: 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.

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 medically necessary Case Management 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
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Benefit Provider - LCSW
Agency	Professional Corporation
Agency	HHA
Agency	DME Provider
Agency	Non-Profit Agency
Individual	HCBS Benefit Provider - MFT

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, §§1409-1419.4

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. “HCB 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 his or her home or place of residence by and HCB Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

A 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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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:

Biennially

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 Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

a. The Licensed Psychologist must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver services as described on the participant's POT as approved by the Waiver Agency or DHCS.

A Licensed Psychologist must provide Medical Equipment Operation 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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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 Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A LCSW is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a LCSW.

Minimum qualifications and requirements for a LCSW functioning as an HCBA Waiver Service Provider are:

1. Have and maintains a current, unsuspended, un-revoked license to practice as a LCSW in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have 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.

a. The LCSW must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. A LCSW 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 Behavioral Sciences
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:

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 services approved under the HCBA Waiver and is enrolled as an HCB 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 section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

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

Minimum qualification and requirements for a Professional Corporation that 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 Corporations Code section 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 Corporations Code section 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. (Corporations Code section 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 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 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 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 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:

DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: 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, Food and Drug Branch
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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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 (PERS) Installation and Testing

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An MFT is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for an MFT.

Minimum qualifications and requirements for a MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has 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.

a. The MFT must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT must provide Personal Emergency Response Systems (PERS) Installation and Testing services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within their scope of practice.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
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.

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 medically necessary Case Management 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	Professional Corporation
Individual	HCBS Benefit Provider - Licensed Psychologist

Provider Category	Provider Type Title
Individual	HCBS Waiver Nurse Provider - RN
Individual	HCBS Benefit Provider - MFT
Agency	HHA
Agency	DME Provider
Individual	HCBS Benefit Provider - LCSW
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 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 services approved under the HCBA Waiver and is enrolled as an HCB 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 section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

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

Minimum qualification and requirements for a Professional Corporation that 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 Corporations Code section 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 Corporations Code section 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. (Corporations Code section 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 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 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 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 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:

DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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 Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

The Licensed Psychologist must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver services as described on the participant's POT as approved by the Waiver Agency or DHCS.

A Licensed Psychologist must provide Medical Equipment Operation 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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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, §§1409-1419.4

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. “HCB 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 his or her home or place of residence by and HCB Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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:

Biennially

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 Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A MFT is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a MFT.

Minimum qualifications and requirements for a MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has 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.

The MFT must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT must provide Personal Emergency Response Systems (PERS) Installation and Testing services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within their scope of practice.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
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:

HHA

Provider Qualifications

License *(specify):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: 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, Food and Drug Branch

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 Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An LCSW is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for an LCSW.

Minimum qualifications and requirements for an LCSW functioning as an HCBA Waiver Service Provider are:

1. Have and maintains a current, unsuspended, un-revoked license to practice as an LCSW in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have 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.

a. The LCSW must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. A LCSW 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 Behavioral Sciences
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:

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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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: 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, ordered by the participant's primary care physician, documented on the POT and authorized by DHCS staff. Services are provided to a waiver participant in his or her home, home-like environment or an approved out-of-home setting.

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 his or her authorized representative(s).

A HCBS RN provides supervision and monitoring of PDN or Shared PDN services if provided by an HCBS LVN.

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

Neither the Waiver Agency, nor DHCS, will approve direct care services or any combination of direct care services and protective supervision services exceeding 24 hours of care per day under this waiver regardless of funding source. Direct care services include State Plan services, such as personal care services through IHSS, adult or pediatric day health care, PDN, shared PDN, and/or direct care authorized by private insurance. Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior in order to safeguard the participant against injury, hazard, or accident.

This waiver service is only available to individuals age 21 and over. All medically necessary 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
Individual	HCBS Waiver Nurse Provider - LVN

Provider Category	Provider Type Title
Agency	HHA

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, §§1409-1419.4

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 his or her home or place of residence by a HCBA Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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:

Individual

Provider Type:

HCBS Waiver Nurse Provider - LVN

Provider Qualifications

License *(specify):*

BPC §§2859-2873.7
CCR Title 22, §51069;

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

Definitions

a. “HCBA Waiver Nurse Provider--LVN” means a Licensed Vocational Nurse who provides HCBA 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. “HCBA 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 his or her home or place of residence by and HCB Waiver LVN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure the health, safety, and well-being of the vulnerable HCBA Waiver population, a 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
• 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 would ensure 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 biennial Waiver Agency oversight visits.

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 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 HCB 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 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 HCB Waiver LVN must notify the Waiver Agency or DHCS and the waiver participant or his or her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the HCB Waiver LVN intends to terminate HCB, 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 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 HCB 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 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 HCB Waiver LVN must notify the Waiver Agency or DHCS and the waiver participant or his or her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the HCB Waiver LVN intends to terminate HCB, 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 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: 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):*

HHA Title 22, §§74659 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:

Transitional 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:**

Transitional Case Management (TCM) services are provided to transition a Medi-Cal waiver eligible individual from a health care facility to HCBS. The Waiver Case Manager will have direct contact with the participant, his or her 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. If the participant should decease before discharge, the TCM services provided may be claimed as an administrative expense under the State Plan's cost allocation plan.

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 medically necessary medical and non-medical care needs, and plan on how the individual's needs are met.

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 medically necessary Case Management 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 Benefit Provider - LCSW
Individual	HCBS Benefit Provider - Licensed Psychologist
Agency	Professional Corporation
Agency	HHA
Agency	Non-Profit Agency
Individual	HCBS Benefit Provider - MFT
Individual	HCBS Waiver Nurse Provider - RN

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 Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A LCSW is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a LCSW.

Minimum qualifications and requirements for a LCSW functioning as an HCBA Waiver Service Provider are:

1. Have and maintains a current, unsuspended, un-revoked license to practice as a LCSW in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Have 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.

The LCSW must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. A LCSW 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 Behavioral Sciences
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: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist.

Minimum qualifications and requirements for a Licensed Psychologist functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California and shall notify DHCS in writing of any change in the status of the license within 5 days of the change in status.

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

The Licensed Psychologist must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. Provide the HCBA Waiver services as described on the participant's POT as approved by the Waiver Agency or DHCS.

A Licensed Psychologist must provide Medical Equipment Operation 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.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology
DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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:

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 services approved under the HCBA Waiver and is enrolled as an HCB 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 section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

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

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

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

Minimum qualification and requirements for a Professional Corporation that 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 Corporations Code section 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 Corporations Code section 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. (Corporations Code section 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 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 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 5 days of the change of licensure status.

b. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 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 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:

DHCS and/or Waiver Agency

Frequency of Verification:

Biennially

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):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional 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 Section 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 three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

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 his or her 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 1000 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: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

HCBA Waiver Standards of Participation

An MFT is an individual who is enrolled to provide services under the HCBA Waiver and who meets and maintains the SOP minimal qualifications for a MFT.

Minimum qualifications and requirements for a MFT functioning as an HCBA Waiver Service Provider are:

1. Has and maintains a current, unsuspended, un-revoked license to practice as a MFT in the State of California, and shall notify the Waiver Agency or DHCS in writing of any change in the status of the license within 5 days of the change in status.

2. Has 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.

a. The MFT must provide the Waiver Agency or DHCS upon initial enrollment and thereafter upon request, adequate documentation of the minimum hours of work experience.

3. The MFT must provide Transitional Case Management services consistent with the participant's choice and interests, the primary care physician's orders and the HCBA Waiver POT within their scope of practice.

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 would ensure 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 biennial Waiver Agency oversight visits.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
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: 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, §§1409-1419.4

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 HCBA waiver in Appendix C (Participant Services), provided to a waiver participant in his or her home or place of residence by and HCBA Waiver RN, within his or her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

To ensure the health, safety, and well-being of the vulnerable HCBA Waiver population, an HCB 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 would ensure 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 biennial Waiver Agency oversight visits.

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:

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 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 1000 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 2000 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 2000 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 2000 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 HCBA 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 1000 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 2000 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 2000 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 2000 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 HCBA 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:

Biennially

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 a 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)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
CLHF	
ICF-DD/CN	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

A CLHF enrolled as a waiver provider has up to 12 beds with most approved waiver providers having between 6 and 10 beds, with an option for a private unit. As a waiver provider these facilities are regarded as the least restrictive alternative home-like setting for certain individuals whose primary need is the availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis and whose medical needs require institutional level of care but who choose to receive their medical services in a home or community setting instead of a skilled nursing facility. Waiver participants residing in this type of facility are regarded as living in their own home, albeit a licensed facility. CLHFs must comply with state landlord and tenant and eviction laws and all local ordinances that apply to other similar residences. CLHF residents have the full array of individual rights and are encouraged to exercise his or her rights.

CLHFs are single family homes situated in residential neighborhoods providing a homelike setting that has private or semi-private bedrooms and access to kitchens and walk/roll in bathrooms.

A CLHF provides sufficient space to allow for the comfort and privacy of each resident and adequate space for the individual to visit with family or friends as well as for staff to complete their tasks. Common areas are used by residents for socialization and recreational activities. Residents are free to have visitors and engage in community outings as desired with the help of family, volunteers and/or staff. The waiver participant's bedrooms have sufficient space for safe storage of the resident's property, possessions, and furnishings and may be personalized and decorated to reflect the preferences of the individual. It also must permit access for the staff to complete their necessary health care functions. The number and size of bathrooms available must allow for the hygiene needs of each waiver participant and the ability of the staff to render care without spatial limitations or compromise. The resident also has the right to maintain access to food and controlling their own schedules. All CLHF residents sign a legally enforceable lease agreement with the residential setting provider.

For participants receiving services in CLHFs, the Waiver Agency or DHCS must determine that the setting is appropriate to the individual's need for independence, choice, autonomy, privacy and community integration. The person-centered process is always used to choose the services and settings and determine if the setting is appropriate to meet the individual's needs and choices and that the setting was selected by the participant from various other settings offered, including a non-disability specific setting. The determination will take into consideration the provision of the following:

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

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

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

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

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

6. Services which meet the needs of each resident.

7. Assurance of residents rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family (if individuals choose to share a residence, visitors are allowed at any time, recognizing the rights of their roommates;) e) use the telephone with privacy; f) choose how and with whom to spend free time; and g) individuals can schedule and take part in community activities of their choice; h) residential units are accessible to the individual and have lockable entrance doors with appropriate staff having keys; and i) entering into an admission agreement and taking occupancy affords residents of licensed residential facilities the same protections from eviction that tenants have under landlord tenant law of the State, county, city or other

designated entity.

The DD/CNC HCBS Facilities are single family homes situated in residential neighborhoods serving no more than eight individuals at any given time. The DD/CNC specializes in serving the developmentally disabled who require extensive physical and developmental services. As a waiver provider, these facilities are regarded as the least restrictive alternative home-like setting for certain individuals whose primary need is the availability of skilled nursing care on a continuous basis and whose medical needs require an institutional level of care but who choose to receive their medical, social and cognitive services in a home or community setting instead of an institution. Waiver participants residing in a DD/CNC are regarded as living in their own home, albeit a licensed facility. The DD/CNC must comply with state landlord and tenant and eviction laws and all local ordinances that apply to other similar residences. DD/CNC residents have the full array of individual rights and are encouraged to exercise his or her rights.

A DD/CNC provides a residential home-like setting that has private or semi-private bedrooms and access to kitchens and walk/roll in bathrooms. It provides sufficient space for the individual to visit with family or friends as well as to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks. Common areas are used by residents for socialization and recreational activities and residents are free to have visitors and engage in community outings as desired with the help of family, volunteers and/or staff. The waiver participant's bedrooms have sufficient space for safe storage of the resident's property, possessions, and furnishings and may be personalized and decorated to reflect the preferences of the individual. It also must permit access for the staff to complete their necessary health care functions. The number and size of bathrooms available must allow for the hygiene needs of each waiver participant and the ability of the staff to render care without spatial limitation or compromise.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

CLHF

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response (PERS) Installation and Testing	
Facility Respite	
Environmental Accessibility Adaptations	
Habilitation Services	
Continuous Nursing and Supportive Services	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	
Waiver Personal Care Services (WPCS)	
Family/Caregiver Training	
Case Management	
Community Transition Services	
Personal Emergency Response Systems (PERS)	

Waiver Service	Provided in Facility
Medical Equipment Operating Expense	
Comprehensive Care Management	
Private Duty Nursing - Including Home Health Aide and Shared Services	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	
Home Respite	
Transitional Case Management	

Facility Capacity Limit:

Up to 12 but most Home and Community-Based Continues Care Facilities have between 6 and 10.

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

ICF-DD/CN

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response (PERS) Installation and Testing	
Facility Respite	
Environmental Accessibility Adaptations	
Habilitation Services	
Continuous Nursing and Supportive Services	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	
Waiver Personal Care Services (WPCS)	
Family/Caregiver Training	
Case Management	
Community Transition Services	
Personal Emergency Response Systems (PERS)	
Medical Equipment Operating Expense	
Comprehensive Care Management	
Private Duty Nursing - Including Home Health Aide and Shared Services	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	
Home Respite	
Transitional Case Management	

Facility Capacity Limit:

No more than eight individuals at any given time

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	

Standard	Topic Addressed
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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.*

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.*

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 HCB Alternative's Waiver services upon evidence the legal representative/legally responsible adult:

1. In areas where a Waiver Agency is not present, the relative or legal guardian must have an active Medi-Cal provider number with an HCB waiver category of service indicator;

2. Meets waiver licensing and/or certification requirements;

3. Meets the HCB 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.

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;
• Community Transition Services;
• Environmental Accessibility Adaptations;
• Family/Caregiver Training;
• Private Duty Nursing;
• Habilitation Services;
• Home Respite;
• PERS Installation and Testing;
• PERS;
• Transitional Case Management; and
• Medical Equipment Operating Expense.

The Waiver Agency or DHCS will notify the waiver participant and/or his or her 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 for enrollment on the waiver. A member of the

Waiver Agency or DHCS must make a LOC assessment visit. 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 ensure that only claims for the amount of authorized waiver services are being paid.

Case management for a RN Independent Nurse Provider would not entail hands on services. It is planning and assisting the participant to access services, evaluating and assessing the participant's needs and filling out the proper paperwork and submitting claims. The Waiver Agency or 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.

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.

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 Section 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 biennial QAR onsite reviews.

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 (CMIPSII).

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. DHCS verifies non-licensed providers continue to meet waiver provider requirements at the point of provider enrollment and as necessary through CMIPSII.

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. Providers that choose to contract with the Waiver Agency will receive a negotiated rate which may be higher than the HCBA Waiver FFS rate. 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 in accordance with the participant's current POT and are medically necessary. Waiver Agencies are also responsible for

submission of all claims for services performed by HCBA Waiver Providers. 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.

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 medically necessary. 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:
Percent of HCBA Waiver providers that were evaluated for compliance with all Federal and State waiver requirements during a timely annual visit by the Waiver Agency. Numerator: Number of waiver providers in compliance with waiver requirements / Denominator: Total number of providers 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:
	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:
Percent of HCBA Waiver provider records that has documentation of completed training within the last 12 months identifying the care needs of the participant. Numerator: Number of provider records showing completed training within the last 12 months / Denominator: Number of providers reviewed.

Data Source (Select one):
Provider performance monitoring
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 Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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:	**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:

Performance Measure:
Percent of HCBA Waiver provider records that have the provider's current license and/or certificate and/or meet the Waiver provider standards as required for each provider type in Appendix C-3. Numerator: Number of provider records that have current license/certificate and meet the waiver provider standards / Denominator: Number of files reviewed.

Data Source (Select one):
Provider performance monitoring
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 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:	**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:
Percent of WPCS providers (non-licensed/non-certified individuals) with signed provider agreements indicating an understanding of the need to provide care in accordance with waiver requirements and the participant's current POT. Numerator: Number of WPCS providers with 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:	**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:

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

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:
Percent of case files with documentation that the WPCS provider has been trained and has the necessary skills, competencies and qualifications. Numerator: Number of files with training documentation for WPCS providers / 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:	**Annually**	**Stratified** Describe Group:
	Continuously and	**Other**

	Ongoing	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:
Percent of HCBA Waiver provider records that has documentation of completed training within the last 12 months identifying the care needs of the participant. Numerator: Number of provider records that has documentation of completed training within the last 12 months / Denominator: Total 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:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

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 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, 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 biennial 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 Waiver specific transition plan, 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 provides the waiver participant, and/or his or her legal representative/legally responsible adult(s), and/or circle of support (et al) with information on the purpose of the POT and encourages them to participate in identifying his or her needs, services, and providers to support and ensure the safety of his or her home program but will provide comprehensive care management at the request of the waiver participant et al. The information is provided verbally at the initial and ongoing face-to-face home visits, as well as in writing through the HCBA Informing Notice and MOHS. During the ongoing home visits, the CMT reviews the POT with the waiver participant et al to ensure the POT accurately reflects the participant's medically necessary 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 et al with information on local non-Medi-Cal, State Plan and waiver services that can meet his or her 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.

The CMT provides training to HCBA Waiver providers, who assist the waiver participant in the development of his or her POT, on the waiver requirement to include the waiver participant et al 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.

Beginning with the application for waiver services and throughout the development of the POT, the waiver participant et al are provided with the opportunity and encouraged to involve individuals of his or her choice in the development of the POT. The "Medi-Cal Home and Community-Based Services Waiver Informing Notice" informs the waiver participant and/or his/her legal representative/legally responsible adult of his or her authority in determining who can assist them in selecting and identifying waiver services and providers. The Informing Notice includes a complete description of the waiver participant's, his or her primary caregiver's, the participant's current primary care physician, HCBA Waiver service providers, the Waiver Agency, if applicable, and the CMT's roles and responsibilities in the development and implementation of the POT.

In some instances, the Waiver Agency responsible for service plan development may also provide Waiver services directly to waiver participants. In some areas, the Waiver Agency may be the only willing and qualified provider of services and developer of an individual's service plan. This situation may arise in rural counties with limited providers, or when a culturally competent provider or waiver Agency with service plan development responsibility is available.

The State will require Waiver Agencies to develop internal P&Ps that describe the specific responsibilities of the CM and distinct responsibilities of the direct care provider. The State will develop a full disclosure form for participants/families to sign prior to enrollment in the waiver in areas with only one willing and qualified Waiver Agency and 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 is also the only willing and qualified provider of direct services, the agency 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 will sign a formal agreement with the State verifying the Waiver Agency's willingness to ensure that that there is a separation between waiver case management and direct services functions and lines of supervision. Lastly, the Waiver Agency will ensure that case management and direct

services staff 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 will ensure that the signed agreement is implemented as described through ongoing monitoring and oversight. This consists of both biennial QARs and ad hoc/as needed onsite visits, quarterly progress report submission/review, and ongoing desk review of case documentation and billing to ensure there is a clear separation of duties.

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, his or her 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, Section 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, Section 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, Section 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.

The CMT provides the waiver participant, and/or his or her 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 his or her needs, services, and providers to support and ensure the safety of his or her home program but will provide comprehensive care management at the request of the waiver participant and/or his or her 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, as well as in writing through the HCBA Informing Notice and MOHS. During the ongoing home visits, the CMT reviews the POT with the waiver participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support to ensure the POT accurately reflects the participant's medically necessary 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 and/or his or her 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 his or her 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.

The CMT provides training to HCBA Waiver providers, who assist the waiver participant in the development of his or her POT, on the waiver requirement to include the waiver participant and/or his or her 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.

Beginning with the application for waiver services and throughout the development of the POT, the waiver participant and/or his or her legal representative/legally responsible adult and/or circle of support are provided with the opportunity and encouraged to involve individuals of his or her choice in the development of the POT. The "Medi-Cal Home and Community-Based Services Waiver Informing Notice" informs the waiver participant and/or his or her legal representative/legally responsible adult of his or her authority in determining who can assist them in selecting and identifying waiver services and providers. The Informing Notice includes a complete description of the waiver participant's, his or her primary caregivers, the participant's current primary care physician, HCBA Waiver service providers, the Waiver Agency, if applicable, and the Waiver Agency's roles and responsibilities in the development and implementation of the POT.

Participants served under the HCBA Waiver will need to have an identified back-up caregiver that 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 identified on 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):

1. The waiver case manager/coordinator is responsible for developing the POT. A waiver case manager/coordinator can be:

A. In areas where there is a Waiver Agency:

- An RN licensed to practice in the State of California, who is under the direction of the participant's current primary care physician.
- A Physician licensed to practice in the State of California who is the participant's current primary care physician.
- LCSW or MSW.

B. In areas where there is no Waiver Agency:

- An RN licensed to practice in the State of California, who is under the direction of the participant's current primary care physician.
- A Physician licensed to practice in the State of California who is the participant's current primary care physician
- An MFT, Licensed Clinical Psychologist, or LCSW.

DHCS policies and procedures require that the participant's CMT include the participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support in identifying the participant's care needs, medically necessary waiver services, and providers in the development of the POT.

When the CMT meets face-to-face with the Participant, the RN completes a comprehensive clinical assessment of the Participant to determine his or her functional need(s) and level of care, and the licensed Social Worker discusses and documents the participant's strengths, capacities, preferences, and desired outcomes. The Social Worker also presents the Menu of Healthcare Services (MOHS) to the participant and his or her circle of support, when possible, and explains each of the available options. The MOHS is a planning instrument the CMT utilizes to help participants make informed choices about the services and providers available to meet his or her preference(s) and need(s). Note: All references to the participant includes the role of his or her legal representative, if applicable.

After the CMT has met with the participant and his or her circle of support to discuss his or /her preferences, goals, and desired outcomes, the CMT is responsible for developing a comprehensive POT. Once developed, the CMT meets with the participant and his or her 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 he or she schedules the selected services. The participant or his or her delegated representative(s) contacts 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 his or her circle of support and the CMT. For example, eligible participants who choose in-home supportive services (IHSS) hire their own personal care providers.

The participant's 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 obtain the current primary care physician-signed POT. "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 where there are no Waiver Agencies and the waiver participant's only service is WPCS then the waiver participant and/or his or her legal representative/legally responsible adult(s) and/or 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 monitors the timeliness of the WPCS only POT.

In addition to the Person-Centered process implemented during the MOHS discussion, the CMT/waiver case manager or coordinator is required to include the participant's goals and desired outcomes in the POT; and, to explain how the

services and supports included in the plan will support each one. The CMT/waiver case manager or coordinator develops the POT based on the participant's preferences and functional need(s) identified through the clinical assessment. Once developed, the CMT/waiver case manager or coordinator reviews the comprehensive POT with the participant and his or her circle of support to ensure it reflects the services and supports that are important to him or her and meet his or her need(s). When the participant is satisfied with the POT, he or she and members of his or her circle of support sign the final version to indicate it accurately reflects the his or her preferences, goals, and desired outcomes.

2. The CMT can use the "Integrated Systems of Care's, Plan of Treatment". In areas where there are no Waiver Agencies and the waiver participant's only service is WPCS then the waiver participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support will utilize the "Integrated Systems of Care Division's, Plan of Treatment". The POT must include the participant's demographic information; treating and current primary care physician information; medical information and diagnosis; HCBA Waiver program and LOC; all required waiver services, including amount, frequency, duration and waiver service provider type; State Plan services; durable medical equipment required; 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.

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 waiver participant, and/or his or her legal representative/legally responsible adult(s), the current primary care physician, and all providers of waiver services sign the completed POT.

The Waiver Agency reviews the completed POT to verify the participant's care needs, the frequency and duration of waiver and State Plan services, providers, and the participant's goals. Back-up systems are also identified. The Waiver Agency's review of the POT is conducted during the initial request for HCBA Waiver services, during the reevaluation of the participant's LOC, at the annual provider visit, and with each request for waiver services. The Waiver Agency may ask for additional documentation supporting the medical necessity of the services described in the POT. Any necessary or suggested revisions of the POT are discussed with the waiver service providers, the participant's current primary care physician, and participant and/or legal representative/legally responsible adult(s) and/or circle of support. Modifications to the POT are made only with approval of the participant and/or his or her legal representative/legally responsible adult and the participant's current primary care physician.

3. The Waiver Agency provides information to the participant and/or his or her legal representative(s), and/or circle of support on the HCBA Waiver and available provider types. This information is provided verbally during the initial and subsequent home visits, and in writing though the MOHS. The MOHS lists all the waiver services and provider types available to the participant. The MOHS is a planning instrument that is used by the participant and/or his or her legal representative/legally responsible adult, circle of support and the Waiver Agency in the development of a home care program, and to ensure the home program meets the HCBA Waiver requirements. The participant and/or his or her legal representative/legally responsible adult(s) and/or his or her circle of support are encouraged to select the waiver service best suited to meet his or her needs during the completion of the MOHS. The participant and/or his or her legal representative/legally responsible adult(s), and/or circle of support are advised to contact, by telephone or in writing, the Waiver Agency when they have questions regarding waiver services and/or providers.

4. The POT process is designed to document the participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support goals for successfully living at home in the community. Waiver participants are encouraged to participate in the development of the POT, choosing waiver services, providers, and treatment options that will assist them in meeting the stated goals. The participant and/or his or her legal representative/legally responsible adult(s) and waiver service providers responsible for the services specified in the plan must sign the completed POT. The Waiver Agency reviews the effectiveness of meeting the goals described in the POT during the LOC reevaluation home visit. In signing the POT, the primary care physician is attesting to the medical necessity of the waiver services identified in the POT.

The Waiver Agency or DHCS assists participants with coordination of waiver and State Plan services, and identifies local resources provided by non-governmental organizations or state and local government agencies for transportation, housing, and nutrition services. However when a waiver participant is enrolled a Managed Care plan, the plan is responsible for coordinating State Plan services for their enrolled members. Therefore, the Waiver Agency or DHCS should coordinate directly with the plan for the provision of State Plan services.

5. The CMT regularly updates the POT, documenting changes in the participant's health status and identifying waiver and non-waiver services needed for the participant to remain safely at home. The Waiver Agency can assist the participant and/or his or her legal representative/legally responsible adult(s) and/or members of the circle of support with identifying providers, or other necessary services.

6. The POT requires the Waiver Agency, to identify waiver services, waiver providers, and the amount and frequency of waiver services. The CMT is responsible for making certain that services are provided in accordance with the POT. The Waiver Agency, reviews the POT while conducting the LOC reevaluation. During the reevaluation, the Waiver Agency, reviews the POT with the participant and/or his or her legal representative/legally responsible adult(s) and/or members of the circle of support to identify any problems in the home care program. The CMT, is required to be present during the participant's scheduled reevaluation. The Waiver Agency conducts the provider visit annually to review the participant's case record and the participant's home program, including implementation of the elements of the POT. The Waiver Agency, together with the participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support, prepares a plan for correction for issues identified during the reevaluation or the annual provider visit.

7. During care management contact/activities, if it is determined that the POT does not reflect the participant's medical needs due to significant changes in the participant's condition, the Waiver Agency must consult with the participant's current primary care physician, and update or revise the POT. "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.

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 ensure 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 ensure 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.

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 medically necessary 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 he or she has reviewed the POT, agrees that it addresses all of the participant's medically necessary health care needs so that he or she 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 back-up 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 back-up 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 back-up 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 his or her 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 qualified and willing to provide State Plan or waiver services. In areas where there is a Waiver Agency, qualified and willing providers must enroll through 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 in areas where there is a Waiver Agency will be provided through the Waiver Agency, in areas where there is no Waiver Agency, providers will bill the FI. The CMT provides the participant and/or his or her 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. Additionally, the CMT provides the participant and/or his or her legal representative/legally responsible adult(s) with the MOHS, which includes the provider types authorized to provide approved waiver services.

DHCS proposes to update the waiver application with the following language: “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.

Waiver participants are encouraged to identify providers of waiver services who can best meet his or her medically necessary 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 locating waiver service providers.

The initial contact with potential participants (and their 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 ensure that the participants have 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 under Services, then Long-Term Care Alternatives.

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 at the time of requested waiver enrollment. POTs not meeting the HCBA Waiver standards shall be adjudicated by a second level review before it is returned to the CMT with instructions regarding needed revisions or additional information. In these instances, the CMT meets with the participant and/or his or her legal representative/legally responsible adult(s) and/or members of his or her 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 medically necessary health care needs, his or her 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 and/or 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.
In addition, DHCS reviews a statistically valid sample of approved POT during the biennial QAR.

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 biennial 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

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.

The CMT, is responsible for coordinating, implementing, and updating the implementation of the POT to ensure it accurately reflects the participant's care needs, and that the participant is receiving the authorized waiver services. The CMT ensures waiver services are furnished in accordance with the POT by maintaining regular contact with the participant and/or his or her legal representative/legally responsible adult and/or circle of support. Contact includes home visits and telephone calls. The CMT is responsible for apprising the DHCS 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 problems, and issues regarding implementation of the participant's POT or his or her health and welfare. The Waiver Agency frequently reviews the CMT's case notes and documentation to ensure that any plan of correction was completed with appropriate follow-up. During regularly scheduled meetings with the participant and/or his/he legal representative/legally responsible adult(s) and/or circle of support, the CMT asks if they are satisfied with the plan of correction and resolution.

At the home visit, the CMT reviews the POT with the participant and/or his or her legal representative/legally responsible adult(s) and/or members of his or her circle of support to:

- Verify the participant's POT is current and signed by the participant and/or legal representative/legally responsible adult, 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 and/or his or her legal representative/legally responsible adults and/or members of his or her circle of support and discuss the recommendations for waiver and non-waiver services and providers of services.
- Ensure the POT meets the participant's medically necessary 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.
- Ensure a complete and accurate written medical record, including diagnoses, complete evaluation, treatment plan, and prognosis is available when determining the medical necessity for the waiver services described in the POT.
- Review the back-up plan in the event a provider is not available. The CMT can assist the participant and/or his or her legal representative/legally responsible adults and/or members of his or her circle of support in identifying providers and community resources as part of his or her back-up plan.
- Document the participant and his or her legal representative/legally responsible adult are instructed and understand how to recognize and report abuse, neglect and exploitation. The POT reflects any risk for abuse, neglect and exploitation and how incidents will be prevented.
- Ensure the written home safety evaluation has been completed and all identified issues are addressed in the POT. The home safety evaluation assesses participant accessibility, structural barriers, utilities, evacuation plans, and communication and fire safety systems and devices.
- Document the participant's home is safe.

The CMT will discuss identified problems or deficiencies in the POT with the participant and/or his or her legal representative/legally responsible adults and/or members of his or her circle of support. Corrections must be made to the POT, which is reviewed and approved by the participant's current primary care physician, before additional waiver services and/or continued enrollment in the HCBA Waiver can be authorized. Health and safety issues described in the POT are documented using the Event/Issue Report and included in the participant's case record. Upon enrollment into the HCBA Waiver, the CMT reviews the initial POT with the participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support. 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 and/or his or her legal representative/legally responsible adult(s) and/or 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 and/or his or her legal representative/legally responsible adult(s) and/or circle of support to determine if the POT continues to meet the participant's medically necessary health care needs.

The level of case management acuity system is used by the CMT to determine the frequency of home visits based upon the participant's risk factors and the complexity of his or her 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 running record section of the participant's case record. Based on interim contact reports and/or information received from the participant, the CMT should update the POT to reflect changes in the participant's medically necessary health care needs, waiver providers, and/or the delivery of waiver services.

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 as desired by the participant. Waiver participants are given the choice of any qualified provider who agrees to furnish waiver services. DHCS ensures that the Waiver Agency is in fact subcontracting with a sufficient number of service providers through biennial QAR's as well as our internal database (MedCompass) where the Waiver Agencies are responsible for importing all of their provider and subcontracted providers information for verification and tracking purposes.

DHCS will monitor the number of providers that a Waiver Agency has within their network and is requiring that they continually enroll willing and qualified new providers, as they are able (DHCS will not require new providers be enrolled if they do not qualify, or if no additional providers are interested), as part of their contract with DHCS. The Waiver Agency must do continuous outreach to expand their provider network. The Waiver Agency will be required to maintain documentation received from all providers requesting to become a service provider which DHCS will review during the biennial onsite visit. The Waiver Agency will be required to provide participants with a directory of available providers within their network and also inform them of their ability to have someone not in the network provide services as long as they are a willing and qualified provider enrolled with Medi-Cal. The Waiver Agency will be required to maintain a record in the case file showing that they have informed the participant of their options which DHCS will review during the biennial audit.

DHCS shall monitor the Waiver Agency's performance biennially through onsite QAR. When corrective action is required, the Waiver Agency responds with a formal Corrective Action Plan (CAP) to address any deficiencies. DHCS may, at its discretion, conduct an on-site follow-up visits to the Waiver Agency to evaluate the effectiveness of the new practice(s). DHCS provides ongoing technical assistance to Waiver Agencies and requires quarterly reports from each Waiver Agency that includes updates on quality assurance activities, incident report, 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 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 significant issues, DHCS would require in writing that the Waiver Agency develop a CAP specific to correcting the issue(s). The Waiver Agency would be required to respond to DHCS within 30 calendar days with a formal written plan to cover any identified deficiencies. The CAP would be specific about the actions to be taken, the personnel who will take the actions, and the 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 approved. DHCS would provide 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:*

In areas where a contracted Waiver Agency is the only willing and qualified provider, the State shall ensure that the Waiver Agency responsible for providing POT development and for providing Waiver services directly to the participant will adhere to the following safeguards:
• Waiver Agency shall develop Policies & Procedures that describe the specific responsibilities of the Waiver Agency, CMT, and the Waiver service providers.
• Waiver Agency shall sign a formal agreement with the State verifying the organization's willingness to ensure that there is a clear separation between lines of supervision, the CMT's provision of Comprehensive Care Management, and the staff who provide Waiver services.
• Ensure the CMT and staff providing Waiver services sign agreements acknowledging their understanding of, and willingness to, comply with mandated separation of Comprehensive Care Management and Waiver service functions.
• Waiver Agency shall submit signed agreements to the State and receive state-approval prior to staff having any contact with newly enrolled Waiver participants.
Waiver Agency 's CMTs will provide the participant with a full disclosure form to review and sign prior to his or her enrollment in the Waiver in areas where the Contractor is the only willing and qualified direct service provider. The form will be provided by the State and will include the following:
• Full disclosure and assurances that participants are supported in exercising their right of free choice in providers;
• Describing the individual dispute resolution process;
• Full disclosure that the Waiver Agency is the only willing and qualified provider available to provide case management and Waiver services in the participant's geographical service area;
• Assurance that the Waiver Agency will separate Comprehensive Case Management and the provision of direct Waiver services (different staff with different lines of supervision);
• Assurance that the Waiver Agency providing Comprehensive Care Management and Waiver services does so only with the approval of the State; and
• That the State will provide direct oversight and periodic evaluation of the effectiveness and appropriateness of established safeguards.

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:
Percent 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 medically necessary 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:	**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:

Performance Measure:
Percent of POTs that documented all waiver and non-waiver services. Numerator: Number of POTs that document all waiver and non-waiver services / Denominator: Number of POTs 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:
	Continuously and	**Other**

	Ongoing	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:
Percent of case records documenting that the participant's medically necessary care needs are being met and that the participant et al are satisfied with the services being delivered. Numerator: Number of case files documenting medically necessary care needs are met and satisfaction with the services being delivered / Denominator: Number of files reviewed.

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

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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

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

Performance Measure:
Percent of participants whose service plans are adequate and appropriate to address their needs and personal goals as indicated in the assessment. Numerator: Number of service plans adequate and appropriate to address needs and personal goals as indicated in the assessment / Denominator: Number of cases 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:
	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:
Percent of current POTs found during the annual Case Record Review indicating service plans are updated/revised at least annually or when warranted by changes. Numerator: Number of POTs 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:	**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: 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:
Percent of case records with documentation by the Care Management Team indicating that services are being delivered as described on the POT. Numerator: Number of case records with documentation by the CMT 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	**Weekly**	**100% Review**

Agency		
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:

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

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.

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 waiver participant's medically necessary care needs, and helping to ensure that the participant is satisfied with how those services are being delivered;
- The current primary care physician is in agreement that the participant is receiving the medically necessary 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.

Waiver Agencies utilizes the following tools for discovery:

- Internet-based Case Management Information System (CMIS) and subsequently MedCompass;
- Care Management Onsite Review;
- Biennial QARs;
- Case Record Review;
- Provider Onsite Visit Review;
- Quarterly Utilization Reports;
- Event/Issue Database (will be integrated in to MedCompass);
- California Medicaid Management Information System (CA-MMIS);
- California Department of Social Services Case Management Information Payrolling System II (CMIPSII); and,
- Management Information and Decision Support System (MISDSS)

MedCompass is a database that was implemented in December 2017. DHCS uses information from MedCompass to establish 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 provides data on how potential participants are referred to the waiver, how many referrals are received, and document the timeliness of the referral, evaluation and enrollment process.
MedCompass captures data on applicants who are placed on the waitlist and tracks the reasons active waiver cases are closed. MedCompass also allows the Waiver Agency to document the utilization and cost of WPCS, as well as track Notice of Actions (NOA) and capture the number of requests for State Fair Hearings along with the outcomes of those Fair Hearings. Prior to MedCompass coming online, DHCS used CMIS for all of the activities listed above.

DHCS is responsible for conducting biennial onsite Waiver Agency QARs and, in areas where there is no Waiver Agency, DHCS clinical reviews, which will consist of 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 onsite QAR, the Case Record Review uses a tool designed to document the following:

- Evidence of the LOC evaluation;
- Evidence that the participant, and/or his or her legal representative/legally responsible adult(s), and/or circle of support, which includes individuals identified by the participant, are involved in the development of the POT;
- Evidence that the POT addresses all the participant's identified medically necessary care needs and assists in assuring the participant's health and welfare;

- Evidence that the participant, and/or his or her legal representative/legally responsible adult(s), and circle of support have received instructional information in recognizing abuse, neglect, and exploitation and are knowledgeable in how to report them;
- Evidence that the POT reflects that all the participant's medically necessary services are planned and implemented in accordance with their unique medically necessary care needs, expressed preferences, personal goals and abilities while keeping the participant's health status in mind;
- Evidence that information and support is available to help the participant, and/or his or her legal representative/legally responsible adult(s) and/or 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 or the Waiver Agency's policies and procedures.

The DHCS Event/Issue database, which will be a part of MedCompass, captures the type and number of events and issues that affect or can affect the health and safety of the waiver participant, the timeliness of the reporting, and the participant's and/or his or her legal representative/legally responsible adults(s), and circle of support's satisfaction with the outcome of the action plan for the reported issue or event. Reports are developed annually and are evaluated for possible remediation actions.

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 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 can 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 medically necessary care needs;
- Continuity of care; and
- Ability to direct the services that meet the participant's medically necessary care needs.

The CMT provides information on participant direction to the participant or legal representative at the face-to-face intake assessment and reassessment visits. The CMT advises the participant or legal representative on the roles and responsibilities of the participant or legal representative, participant's current primary care physician, DHCS, the Waiver Agency, and the provider 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 Respite Care services can select an unlicensed adult who is not the spouse, or legally responsible adult, parent, stepparent, or foster parent of a participant, and 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
- Private Duty Nursing
- Transitional Case Management
- Family Training
- Respite Care

Participants or legal representative may select individual licensed providers to facilitate the provision of, and Medi-Cal billing for, the following services:

- Environmental Accessibility Adaptations
- Personal Emergency Response Systems – Installation and Testing
- Personal Emergency Response Systems
- Medical Equipment Operating Expenses

The following individual licensed providers are eligible to enroll as wavier providers:

- Registered Nurse
- Licensed Vocational Nurse
- Licensed Clinical Social Worker
- Marriage and Family Therapist
- Licensed Psychologist

Participants or legal representatives can obtain lists of unlicensed providers from the Waiver Agency or 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. 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 subcontracting or enrollment process, and the roles and responsibilities of becoming a waiver provider.

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 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 ensure 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 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 oversees 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 DHCS in areas where there is no Waiver Agency.

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 HCBA Waiver Informing Notice and the MOHS.

If the participant or legal representative expresses interest in selecting an unlicensed provider to provide WPCS and/or Respite 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 Waiver Personal Care 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
Personal Emergency Response (PERS) Installation and Testing		
Facility Respite		
Environmental Accessibility Adaptations		
Habilitation Services		
Continuous Nursing and Supportive Services		
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services		
Waiver Personal Care Services (WPCS)		
Family/Caregiver Training		
Community Transition Services		
Personal Emergency Response Systems (PERS)		
Medical Equipment Operating Expense		
Private Duty Nursing - Including Home Health Aide and Shared Services		
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services		
Home Respite		
Transitional Case Management		

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

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 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.

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
Personal Emergency Response (PERS) Installation and Testing	
Facility Respite	
Environmental Accessibility Adaptations	
Habilitation Services	
Continuous Nursing and Supportive Services	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	
Waiver Personal Care Services (WPCS)	
Family/Caregiver Training	
Case Management	
Community Transition Services	
Personal Emergency Response Systems (PERS)	
Medical Equipment Operating Expense	
Comprehensive Care Management	
Private Duty Nursing - Including Home Health Aide and Shared Services	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	
Home Respite	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Transitional Case Management	

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:

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 and MOHS. Upon enrollment in the waiver, the participant is assigned a DHCS MC.

The DHCS MC advises the participant or legal representative of his or her 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 the MOHS, 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.

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 upon the decision 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 ensure there is no 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 HCBA Case Management Providers (Nurse or Social Worker) who prepared the POT.

If the participant or legal representative is unable to secure an alternative waiver provider, the CMT 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 the provider to provide 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 him or her of the decision to terminate participant directed services and his or her appeal rights.

Safeguards to ensure 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. This will ensure that the quality of care is maintained and there is no break in waiver service. 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	4974	
Year 2	4974	
Year 3	6974	
Year 4	7974	
Year 5	8974	

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 acts as a common law employer. Unlicensed providers must enroll as an IHSS provider at the county's DSS office. Payment for WPCS is processed through DSS' CMIPS II.

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 or his or her 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 and/or his or 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 new or previously authorized waiver services. The NOA includes instructions advising the participant and/or his or her authorized representative(s) on how to request a State Fair Hearing before an Administrative Law Judge (ALJ). 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. The participant and/or his or her 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 was issued because the participant no longer met the waiver requirements or LOC, the participant no longer met the waiver's income and resource eligibility requirements, or the participant no longer met regular Medi-Cal eligibility requirements.

Upon request of a State Fair Hearing, the Waiver Agency or DHCS staff will contact the applicant or participant and/or his or her 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 his or her legal representative/legally responsible adult(s) have not identified legal representation, the Waiver Agency or DHCS will refer the participant and/or his or her 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 his or her 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 to reduce, terminate, or deny continued enrollment in the waiver and/or a waiver service(s), any aid paid pending the participant had been receiving 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 medically necessary services and supports to ensure 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 on the POT, and the Waiver Agency or DHCS determines that such compliance is necessary to assure the health, safety, and welfare of the participant.
•The participant or the legal representative/legally responsible adult(s) does not cooperate in attaining or maintaining the POT goals, thereby jeopardizing his or her 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 back-up 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 ensure the health and safety of the Participant's circle of support.
•The participant and/or his or her 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 In-Home Supportive Services (IHSS) Personal Care Services (PCS) and WPCS, 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 he or she is 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 greater 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.

Currently all notices of adverse actions and the opportunity to request a Fair Hearing are kept in each participant's file. In the future, all notices will be housed in our MedCompass Database where both DHCS and providers will have access to view.

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 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 structures and the participants they serve. Grievance policies and procedures are subject to review and approval by DHCS during QAR and as necessary. DHCS provides technical assistance to Waiver Agencies handling complaints, grievances, and complicated situations. Waiver Agencies report in their quarterly utilization reports 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.

Currently all notices of adverse actions and the opportunity to request a Fair Hearing are kept in each participant’s file. In the future, all notices will be housed in our MedCompass Database where both DHCS and providers will have access to view.

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 his or her 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 Quarterly Progress Reports.
DHCS reports serious issues to CDPH immediately following verification. Timeliness is monitored by tracking when DHCS was notified of an issue and when DHCS notified CDPH of the issue, the MedCompass system will allow for both of these items to be tracked and reportable.

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 him or her, his or her 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 at the next 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 he or she 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 California Department of Public Health 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, his or her legal representative/legally responsible adult(s) and/or members of his or her 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, his or her legal representative/legally responsible adult(s), service/care providers, and/or circle of support to ensure timely investigation and resolution. If an event/issue is observed by a waiver provider it must be reported to the Waiver Agency or DHCS. 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 ensure 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; and
•Local law enforcement.

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 Sections 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/or his or her 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, and L&C actions and 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 and/or his or her legal representative/legally responsible adult(s) and/or circle of support, to ensure 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, his or her legal representative/legally responsible adult(s), and/or members of his or her 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, his or her current primary care physician, and all waiver service providers receive the "HCBA Waiver Informing Notice" that includes a description of the roles and responsibilities of the participant, caregivers, 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 and/or his or her legal representative/legally responsible adult(s), his or her primary caregiver and 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 ensure they are appropriate, will result in a resolution amenable to the participant and/or his or her legal representative/legally responsible adult(s), and will ensure 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 his or her 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 proven that a waiver participant suffered an instance of abuse at the hands of a 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 ensure that the participant receives their medically necessary 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 ensure their safety throughout the transition process.

The Waiver Agency or DHCS tracks events/issues referred to CDPH, L&C to ensure that the Waiver Agency or DHCS can adequately respond to the reported findings and plan for resolution of the event/issue. The Waiver Agency or DHCS will follow 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 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 Quarterly Progress Reports (QPR). During the biennial 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 ensure the issues have been resolved.

Biennial 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/or his or her 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 ensure that the monitoring of remediation activities of all critical incidents and events is systemically conducted.

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 telephone contact with the participant, his or her 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 himself/herself 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 ensure 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.

DHCS will ensure the Waiver Agency maintains policies and procedures regarding provider use of restraints that reflect regulatory compliance and which include provider training requirements.

The CMT will ensure the providers/caregivers in the home have been adequately trained in the application and monitoring of physical restraints. This is achieved by 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 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.

If the Waiver Agency or DHCS has determined that physical restraints used for a participant living in his or her home are 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. DHCS will ensure the Waiver Agency maintains 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, Adult or Child Protective Services 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 were additional Waiver participants remaining at the facility, DHCS would ensure that there was no additional unauthorized use of restraints on the remaining participants. Actions taken by DHCS could include but are not limited to; unannounced site visits, requiring the facility to submit a corrective action plan, suspension of new enrollments, and suspension of the provider requiring the transition of all remaining waiver participants to other appropriate settings.

The unauthorized use of restraints in the home are reported to Adult or Child Protective Services and sanctions may be imposed by law enforcement.

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 and child or adult protective services 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 telephone contact with participants, his or her legal representative/legally responsible adult(s), waiver providers and participant's current primary care physician. The CMT ensures all requirements are followed by observation and interaction, if possible, with the participant, 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 or ICF/DD-CN 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 we are able to identify the seriousness of the incident along with 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/biennial audit, DHCS compares what we have received for incident reports to what is on file with the providers to ensure we are informed of all incidents. If there is a discrepancy, DHCS may issue a CAP 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 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 telephone contact with the participant, his or her legal representative/legally responsible adult(s), service providers, and participant's current primary care physician. If the the Waiver Agency or DHCS observes or learns that restrictive interventions are being used, an Event/Issue Report form must be completed, and the appropriate law enforcement and child or adult protective services 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 to investigate and follow up on their findings. The Waiver Agency and DHCS are responsible for monitoring 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 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 or HCBA Case Management Provider, and/or via telephone contact with participants, his or her legal representative/legally responsible adult(s), waiver providers, and 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 the appropriate law enforcement, and either child or adult protective services. The Waiver Agency or DHCS shall refer the unauthorized use of seclusion by an HHA, PDHC, CLHF or ICR/DD-CN to CDPH, L&C to investigate and report on their findings. The Waiver Agency and DHCS are responsible for monitoring 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.

A CLHF and an ICF/DD-CN residence is responsible for medication management for Waiver participants unless the participant has a current primary care physician order to self-manage his or her medications.

A RN employed by the CLHF or ICF/DD-CN is required to complete an initial assessment that includes reviewing medications to ensure the participant's medication needs are identified during the assessment process and are reviewed and 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 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 ensure 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 ensure 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 the CDPH, Regional Centers, DHCS and the Waiver Agency.

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 ensure that necessary changes have occurred and continue to be applied, and that corrective actions insure 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 but 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 with 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 ensure that persons responsible for the administration of medications are trained to ensure 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 ensure 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 ICFDD-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 DHCS with their 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 corrective action plan, 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 biennial 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 CAP. Once a CAP is received from the provider, a follow up visit is conducted by DHCS to ensure 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 in which we are able to identify the incident along with 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 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.

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:
Percent of HCBA Waiver cases meeting DHCS' policies and procedures indicating they are appropriately documented in the Event/Issue database. Numerator: Number of cases that are appropriately documented in the event/issue database / 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 = 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**

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:

Performance Measure:
Percent of events/issues that have documentation indicating they have been resolved. Numerator: Number of events/issues that have been resolved / Denominator: Total number of events/issues reported.

Data Source (Select one):
Program logs
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 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 = 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:

Performance Measure:
Percent of case records documenting 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:

	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:
Percent of case records documenting that the participant, family and/or circle of support are aware of how to report instances of abuse, neglect or exploitation. Numerator: Number of cases documenting participants/family/circle of support know how to report 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:
	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:

Performance Measure:
Percent of unexplained death that documents appropriate action and follow up. Numerator: Number events/issues reported due to unexplained death with appropriate action and follow up / Denominator: Number of events/issues reported due to unexplained death.

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:	**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 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:
An incident management system is in place that effectively resolves incidents and

prevents similar incidents. Numerator: Incidents resolved / Denominator: Number of incidents reported.

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:	**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:

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:
Percent of HCBA Waiver cases meeting DHCS' policies and procedures regarding the use of restraints. Numerator: Number of cases appropriately documented regarding the use of restraints / Denominator: 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 = 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:

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:
The state monitors overall health care standards based on the approved waiver.
Numerator: Cases reviewed that meet standards / Denominator: Number of cases 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:	**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 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 and appropriate local or State agencies.

Following the biennial 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 program, DHCS' Eligibility Division updates their eligibility in the system and a NOA is sent out notifying the participant/family that eligibility has been terminated. Any actual "unexplained" death would be reported to a DHCS Case Manager along with the appropriate law enforcement and either Child or Adult Protective Services 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 performs continuous and ongoing reviews of HCBA Waiver Agency compliance standards, administration and care management activities, participant and provider records and financial statements through its required reporting process, the Quarterly Progress Report (QPR). 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 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 through the QPRs. The analysis of the QPRs allows DHCS to determine that documentation was done on a timely basis, with the appropriate forms and done by appropriate personnel. The specific areas of review include administrative accountability, LOC assessments, care plan, service authorization, service provision, provider qualifications, provider performance/complaints, financial integrity and sustainability and Participant health and welfare.

When an individual problem is identified during the QPR process, DHCS will issue a written report of the findings and recommendations to the Waiver Agency that will include a formal written request for a CAP specific to remediating the problem. The Waiver Agency is required to respond to DHCS with a formal written plan to cover any deficiencies identified within 30 calendar days.

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 CAP, DHCS monitors the Waiver Agency’s resolution process to ensure complete remediation of the deficiency. Once the CAP is reviewed by DHCS, the Waiver Agency is given an opportunity to implement the developed strategy. Once implementation has occurred, 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 requests 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 performs biennial onsite reviews to each Waiver Agency, called Quality Assurance Reviews (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, the HCBA Waiver Agency Manual updates and policy letters, if needed. DHCS also provides technical assistance onsite or through on-going email and telephone contact between the Waiver Agency and DHCS. DHCS uses this aggregate data to prioritize training needs in order to schedule multi-Waiver Agency training events.

While performing the QAR, should DHCS discover that a specific Waiver Agency has significant issues, DHCS would require in writing that the Waiver Agency develop a CAP specific to correcting the issue(s). The Waiver Agency would be required to respond to DHCS with a formal written plan to cover any deficiencies identified within 30 calendar days. The CAP would be specific about the actions to be taken, the personnel who will take the actions, and the 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 approved. Technical assistance would be provided during the QAR and throughout the entire issue resolution process.

Incidents involving ICF/DD-CN residences are also reported to CDPH. These include, but are not limited to:

- Hospitalization and/or emergency room transfer
- Facility transfer/discharge
- Accident with injury
- Death
- Any unusual occurrence

CDPH has the authority through H&S Code §1420 to investigate and determine the required remediation. CDPH will maintain a reported event/complaint log of incidents, complaints and exceptional events/unusual occurrences.

Reported Events are defined as actions, events or behaviors that place the participant at risk or describe a change in healthcare status.

- Transfer to the emergency room
- Unplanned transfer or discharge

- Death

Complaints are defined as concerns expressed by participants, family members or others that indicate a perception that the participant is at risk:

•Expressions of dissatisfaction with quality of services,
•Expressions of dissatisfaction with types of services
•Expressions of dissatisfaction with timeliness of services,
•Expressions of dissatisfaction with waiver service providers (individuals or agents/employees of provider entities),
•Communication issues.

CDPH will maintain a reported event/complaint log of incidents, complaints and exceptional events/unusual occurrences. CDPH and DHCS ISCD staff will analyze discovery findings for significance and determine the appropriate response on a continual basis as incidents, events or complaints become known to DHCS.

DHCS responses to reported events, complaints, and exceptional events/unusual occurrences depends on the seriousness of the events reported. An emergency incident, event or complaint with serious allegations would elicit an immediate response, including contacting law enforcement and other responsible agencies immediately if the health or safety of a Waiver Participant appears to be in jeopardy.

For events, incidents or complaints that are not considered emergencies, DHCS will analyze the situation to determine whether a CAP is necessary, and will formulate the appropriate response to resolve a specific dispute or complaint or adopt a process to avoid future events or incidents. If necessary, the process for requesting a CAP and verifying compliance will be the same as outlined in this section. If an immediate response or CAP is not determined to be necessary, DHCS may elect to utilize the QPR process outlined in this section to address the documented issues.

DHCS will report the results of analysis or action taken on individual complaints to affected Participants and their family/legal representative, as needed. Results are also communicated quarterly and at annual review meetings with agencies and waiver providers. It is anticipated that there will be constant interaction between Waiver Agencies and DHCS.

DHCS conducts regular and ongoing oversight of the Waiver Agencies through two primary processes. On a quarterly basis, Waiver Agencies are required to submit QPRs. The QPRs include reporting on enrollments in process, new enrollments, dis-enrollments, grievances/appeals, provider appeals, provider enrollment and qualifications, and special incident reporting. DHCS monitors these reports through trend analysis to identify patterns and will provide technical assistance to Waiver Agencies, require corrective action, or schedule site visits as determined necessary. On a biennial basis, DHCS performs an onsite review of each Waiver Agency, called a QAR. During the QAR, DHCS reviews Waiver Agency case files to ensure that all required performance measures are being met, confirming that assessments, re-assessments and authorizations are performed on a timely basis, confirming that provider payments align with set rates and negotiated agreements, to verify the resolution of grievances/appeals and special incidents, etc. DHCS will also schedule Waiver participant and provider interviews while onsite. All findings will be communicated to the Waiver Agency through a letter following the QAR and the Waiver Agency will be notified if a corrective action plan is required. If a CAP is required, the Waiver Agency must submit within 30 days. DHCS will review and determine if sufficient or if further action is required (i.e. enrollment suspension, follow-up site visit).

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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
Sub-State Entity	**Quarterly**
Quality Improvement Committee	**Annually**
Other Specify:	**Other** Specify: Biennially

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 CMS372 Reports, DHCS reviews the effectiveness of existing quality assurance systems to determine continued efficacy. SHCS 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 our internal monitoring and oversight. Claims data is run through our business objects portal and allows the State to monitor the services being provided, at what frequency and to which participants. All of this information allows the State to validate the information that is documented on the POT and in the LOC determination/redetermination. If DHCS finds a discrepancy, an audit may be triggered prior to the annual/biennial 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 billings to ensure claims are appropriate, and may trigger an on-site review. The annual audit is conducted by the Waiver Agency to monitor and ensure adequate provider performance and adherence to waiver requirements. The biennial audits are on-site Waiver Agency QAR, 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 where there is no Waiver Agency, DHCS will visit providers on-site and review the information and documentation above. The quality review referenced in the application refers to the biennial QAR.

c. The results of the QAR include corrective action as appropriate. The Waiver Agency responds with a formal Corrective Action Plan (CAP) to address any deficiencies. Upon initial approval of the CAP, DHCS monitors the resolution process of the Waiver Agency to ensure complete 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 CMIPSII 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 ensure 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. For issues concerning fraud, DHCS refers to A&I.

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 is only eligible to bill for the waiver services they authorize and assure have been delivered. The billing is via standardized billing forms and claims are submitted to the FI for payment. Only recognized Medi-Cal billers may be paid 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 Audits & Investigations (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 selected 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, Section 14124.2, or collection of overpayments. A&I has three branches that conduct reviews using various methodologies to ensure 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 (IB) 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.

WPCS claims are paid through DSS', IHSS program, CMIPSII.

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 ensure competency and accuracy in the paid claims.

Individual, unlicensed providers of WPCS claims are paid through DSS', IHSS program, CMIPSII, developed and managed by HP Enterprise Services. HP Enterprise Services will continue to oversee the CMIPSII system. CMIPSII validates provider claims with authorized hours and will reject any claim that exceeds the monthly authorized hours. If the received claim is correct, CMIPSII will authorize payment.

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:
Percent of Waiver claims that were coded and paid at appropriate levels. Numerator: Number of waiver claims coded and paid at appropriate levels / Denominator: Number of waiver claims reviewed.

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:*

Performance Measure:
Percent of Waiver claims paid that match the participant's POT. Numerator: Number of claims paid that match the participant's POT / Denominator: Number of waiver claims reviewed.

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:*

Performance Measure:
Percent of Waiver claims billed after the participant's date of enrollment. Numerator: Number of claims billed after the participant's date of enrollment / Denominator: Number of waiver claims reviewed.

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***

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:*

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:
Percent of approvable reimbursements rates. Numerator: Approvable reimbursement rates reviewed / 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 CMIPSII 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 QURs and QARs to gather data for the Financial Accountability Review which analyzes Waiver Agency and statewide trends to ensure 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 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. For issues concerning fraud, DHCS refers to A&I.

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 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 found in the Current California Medi-Cal Fee Schedule published at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/homecd_o07.doc

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 availability and utilization of providers and services. 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 will be 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. These increases were adopted through the annual Medi-Cal budget process which affords various opportunities for stakeholder participation. These increases do 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 the existing published Medi-Cal provider rates found in the current Medi-Cal Fee Schedule located at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/homecd_o07.doc and 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 case management, community transition services and/or transitional case management to Waiver Participants. Rates paid for HCBA Waiver care management services to individual providers when Waiver Agencies are not available 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 grouped according to LOC and bed size. 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: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Attachment_4.19-D2016.pdf

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 that 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)*

MEDIAN RATE METHODOLOGY:
In areas where Waiver Agencies will be available, the State is proposing to apply the median rate to the HCBA Waiver's Comprehensive Care Management, community transition and transitional care management services 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 section 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 biennial QARs. DHCS will ensure contracts between Waiver Agencies and providers are in place, and will review the negotiated rates and invoices to ensure validity based on the rationale.

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 medically necessary services. Waiver participants who utilize the HCBA Waiver Personal Care Services (WPCS) must also be eligible for and receive the State Plan benefit, In-Home Supportive Services (IHSS). Both WPCS 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 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 W&I 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, which 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 ensures that the rates for WPCS 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, Section 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 published at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/homecd_o07.doc 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 and verifies that the requested services are in accordance with the participant's POT and are medically necessary. HCBA Waiver service providers are responsible for submitting a TAR to the Waiver Agency for prior authorization of all HCBA Waiver services except the WPCS benefit. The Waiver Agency reviews the TAR for medical necessity and to ensure services are authorized in accordance with the participant's POT. Claims for services are paid to Waiver providers and Waiver Agency after the service is rendered.

DHCS CA-MMIS Division has overall responsibility for ensuring payment of Medi-Cal claims for provided services. CA-MMIS Division oversees the contract with the FI who 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 adjudicates 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 adjudicated daily. The Medi-Cal FI forwards a payment tape weekly to the State Controller's office for a checkwrite and the provider is notified through a Remittance Advice Detail form.

WPCS claims by unlicensed individual care providers are paid through CDSS, IHSS, CMIPSII.

The CMT authorizes WPCS 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 hours, they submit a WPCS Authorization Letter to DHCS to enter the authorized number of WPCS hours into the California Department of Social Services' (CDSS') Case Management, Information and Payrolling System (CMPIS II). DHCS notifies the Waiver Agency when the participant's WPCS hours are in CMPIS II, and then sends timecards to WPCS providers with instructions on how to report the WPCS hours provided to the waiver participant.

WPCS providers submit monthly timesheets signed by the waiver participant or his or her legal representative/legally responsible adult(s) to their County social services' office for review and approval. The timesheets are reconciled with the hours authorized in accordance with the waiver participant's authorized hours as identified in the POT, and entered into CMIPS II. 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. CMIPSII 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 medically necessary.

In areas with 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 medically necessary. HCBA Waiver providers are responsible for direct submission of claims to the FI.

Claims for waiver services must meet either the CA-MMIS or CMIPSII requirements for processing, including program edits and audits. Submitted claims are reviewed to ensure that all required information is present.

There are several layers of billing validation to ensure 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. Only an eligible Waiver participant may enroll in the Waiver and receive services. After enrollment, services must be documented in their POT and must be authorized before the service is provided; therefore, the participant is eligible on the date of service. DHCS conducts biennial QARs to verify services were provided. The FI has edits and audits in place to pay only valid claims. CA-MMIS does not pay negotiated rates as those reimbursements are made through the Waiver Agency to the designated waiver providers. DHCS only pays the tiered Comprehensive Case Management rate to Waiver Agencies based on 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;*
- *Participant is a Medi-Cal member and is enrolled in the HCBA Waiver;*
- *Satisfactory Medi-Cal eligibility status;*
- *Provider is an enrolled Waiver Agency or HCBA Waiver provider;*
- *Claim is not a duplicate;*
- *Claim is paid per the published rates or Waiver Agency negotiated rate;*
- *Participant was not institutionalized during the time covered by the claim; and*
- *Appropriate HCBA Waiver procedure codes.*

Completed WPCS claims processed through CMIPSII are run against system edits and audits to verify:

- *Services are prior authorized;*
- *Participant is authorized to receive services through IHSS and is enrolled in the HCBA Waiver program;*
- *Provider is enrolled as a WPCS provider authorized to provide services to the HCBA Waiver participant;*
- *Claim is not a duplicate;*
- *Claim does not exceed maximum authorized hours; and*
- *Participant was not institutionalized for more than seven days during the time covered by the claim.*

DHCS conducts biennial QARs to verify services were 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:

The Case Management Information and Payrolling System (CMIPS) II is the statewide database used for case management, payroll, and reports for WPCS reimbursement. CMIPS II supports case management and payroll functions for the In Home Supportive Services (IHSS) program and the Waiver Personal Care Services (WPCS) program. IHSS is not a waiver service, but WPCS is included under the HCBA Waiver. The California Department of Social Services (CDSS) is responsible for the management and oversight of CMIPS II.
The implementation of CMIPS II provided the state with a web based case management platform that would also serve as a means of central processing 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 via a centralized database.
IHSS and WPCS 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 IHSS/WPCS timesheet online by using a tablet, smartphone, laptop, or computer. The ETS system interfaces with CMIPS II and providers who utilize ETS are paid in the same manner as providers who utilize paper timesheets. CDSS is responsible for ensuring IHSS and WPCS providers are paid each month. IHSS and WPCS providers do not receive payments directly from DHCS.
Every month, CDSS provides DHCS with a formatted file comprised of WPCS utilization data. The file represents all of the claims for WPCS 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 that has been allotted for IHSS and any cost associated with facilitating WPCS. DHCS Accounting enters the FMAP into the quarterly CMS 64 report.

Separately, flat rate payments for HCBA Waiver Comprehensive Care Management services will be based on monthly enrollment numbers and participants' care management within tiered acuity levels. At the end of each month, DHCS will run an enrollment report in the MedCompass Case Management Information System to verify the number of enrolled participants served by each Waiver Agency. The report will also identify the number of participants at each level of care 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 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 must 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 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 anticipated to be 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 for 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:

Applying to become an HCBA Waiver Agency

The Waiver Agency are procured through the State contracting process that involves a Solicitation for Application (SFA).

Provider Number

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 ensure 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 determined to be a qualified waiver provider based on the provider qualifications outlined in the waiver application. Providers that choose to contract with the Waiver Agency will receive a negotiated rate, which may be higher than the HCBA Waiver FFS rate. 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 in accordance with the participant's current POT and are medically necessary.

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 medically necessary. HCBA Waiver providers are responsible for direct submission of claims to the FI.

Informing New Enrollees

Once an individual is determined eligible to enroll in the HCBA Waiver, a qualified care manager describes the HCBA Waiver services, limitations, requirements and any feasible alternative programs to him/her, including the option of being institutionalized as compared to receiving HCBS through the HCBA Waiver. The qualified care manager answers any questions the interested individual/applicant may have.

Enrollment and Selections

In order to participate in the HCBA Waiver, a completed HCBA application packet must be received by DHCS which demonstrates the applicant's medically necessary needs and eligibility qualifications.

Waiver Agency Requirements

The State requires Waiver Agencies to have a formal contracting process to monitor the provision of services by all qualified and willing providers.

Monitoring of Waiver Agency providers

DHCS performs biennial QARs, at least on a biennial basis, on all Waiver Agencies. During the QARs, DHCS ensures 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. QARs ensure that the Waiver Agency's contracting process meets DHCS' requirements, that the vendors are qualified, that the appropriate services and amount of services are being billed for in accordance with the Waiver Participant's POT, and the appropriate provider is providing these services. If DHCS finds in the internal monitoring and oversight of claims data that there are discrepancies, an audit of the provider prior to the biennial audit may occur.

Freedom of Choice of Providers

DHCS maintains an approved waiver provider list from which waiver participants are able to choose which providers they would like to use. Providers not on that list and requested by a participant are required to apply to become a waiver provider in order to furnish waiver services. In areas where there is a Waiver Agency, the provider will be enrolled via the Waiver Agencies policies to ensure they are in fact a qualified provider. In areas where there is no Waiver Agency, DHCS will ensure that the provider applicant is qualified 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.

not selected

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:*

In the CLHF and the ICF/DD-CN residences the waiver participant pay the facility directly for the provision of room and board at the beginning of the month from his or her 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 rendered 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	45124.85	44545.00	89669.85	122207.00	7244.00	129451.00	39781.15
2	53529.94	44545.00	98074.94	124332.00	7244.00	131576.00	33501.06
3	60747.07	44545.00	105292.07	126517.00	7244.00	133761.00	28468.93
4	61899.18	44545.00	106444.18	128765.00	7244.00	136009.00	29564.82
5	63058.34	44545.00	107603.34	131077.00	7244.00	138321.00	30717.66

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	6050	2360	3630	60
Year 2	7150	2789	4290	71
Year 3	8250	3218	4950	82
Year 4	9350	3647	5610	93
Year 5	9871	3850	5923	98

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 five years of 372 reports (2011 through 2015) to determine the ALOS was 328 days. The state used 328 as a base for WY 1 and WY 2. The state expects ALOS to increase by 3% each waiver year, effective January 2019, after the implementation of the new model. The projected ALOS for each year of the Waiver are included below.

Average Length of Stay Projections:

2017 & 2018 = 328

Projected Increase = 3.0%

Therefore:
2019 = 338
2020 = 348
2021 = 358

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 5 (January 1, 2011 – December 31, 2011)
WY 1 (January 1, 2012 - December 31, 2012)
WY 2 (January 1, 2013 - December 31, 2013)
WY 3 (January 1, 2014 - December 31, 2014)
WY 4 (January 1, 2015 – December 31, 2015)

The following are assumption also used in deriving the Factor D:

• The state estimated 90% of the waiver population would be served under Waiver Agencies utilizing Comprehensive Care Management services while the state would directly provide Case Management services to 10% of the waiver population.
• The state added 1000 slots in each waiver year for a total of 5000 slots added through WY 5
• Waiver participants under 21 years of age receive waiver services when like services are not available through the State Plan.
• Community Transition Services benefit is capped at a lifetime benefit of $5,000. (Under certain circumstances described in Appendix C, the "lifetime" benefit cap may be waived.)
• Environment 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 $47.50 is used based on reported utilization obtained from CMS 372 reports.
• The average reimbursement rate for a waiver service is derived from averaging rates of reimbursement 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 2011-2015.
• 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.

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 5 (January 1, 2011 – December 31, 2011)
WY 1 (January 1, 2012 - December 31, 2012)
WY 2 (January 1, 2013 - December 31, 2013)
WY 3 (January 1, 2014 - December 31, 2014)
WY 4 (January 1, 2015 – December 31, 2015)

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 2011-2015.
• 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 365 consecutive days. 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 365 days a year. This establishes an annual cost by level of care. NF/B LOC is expected to have a yearly rate increase of 4%. The calculated percentages of beneficiaries enrolled in each level of care in the waiver is as follows: 55% in NF/B; 40.1% in NF Subacute Adult; 1.1% in Acute Hospital, and 3.8% in ICF-DD Non-Vent.

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' estimates for State Plan services utilized during 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 NF/AH and IHO 372 reports. The CMS 372 Reports used:

WY 5 (January 1, 2011 – December 31, 2011)
WY 1 (January 1, 2012 - December 31, 2012)
WY 2 (January 1, 2013 - December 31, 2013)
WY 3 (January 1, 2014 - December 31, 2014)
WY 4 (January 1, 2015 – December 31, 2015)

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.

In the renewal, Factor G' was calculated to be $7,214 based on G' 372 historical data in 2012 through 2014 (3 years of data). In this amendment, Factor G' was calculated to be $7,244 based on G' 372 historical data in 2011 through 2015 (5 years).

The state chose to include five years of data instead of three, to align with all other data within Exhibit J using a 5-year look-back. The estimate originally entered for Community Transition Services was entered in error and has been updated to reflect actual estimate based upon historical use of the service. There are no changes to the logic behind the revision.

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)	
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:						1282528.91
Case Management	Quarter Hour	1815	66.35	10.65	1282528.91	
Habilitation Services Total:						126759.90
Habilitation Services	Quarter Hour	31	402.86	10.15	126759.90	
Home Respite Total:						31920.15
Home Respite	Quarter Hour	8	675.13	5.91	31920.15	
Waiver Personal Care Services (WPCS) Total:						95053414.10
Waiver Personal Care Services Regular Time	Hour	3710	1844.73	12.88	88150054.10	
Waiver Personal Care Services Overtime	Hour	850	1440.00	5.64	6903360.00	
Community Transition Services Total:						38610.00
Community Transition Services	Event	65	1.00	594.00	38610.00	
Comprehensive Care Management Total:						13975500.00
Comprehensive Care Management	Months	4235	12.00	275.00	13975500.00	
Continuous Nursing and Supportive Services Total:						22936413.47
Continuous Nursing and Supportive Services	Day	289	213.95	370.95	22936413.47	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						4065.00
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-	Months	1	1.00	4065.00	4065.00	

GRAND TOTAL:	273005366.11
Total Estimated Unduplicated Participants:	6050
Factor D (Divide total by number of participants):	45124.85
Average Length of Stay on the Waiver:	328

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Ventilator Dependent Services						
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						2582672.40
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	21	288.75	425.92	2582672.40	
Environmental Accessibility Adaptations Total:						125000.00
Environmental Accessibility Adaptations	Event	25	1.00	5000.00	125000.00	
Facility Respite Total:						16965.18
Facility Respite	Day	6	9.00	314.17	16965.18	
Family/Caregiver Training Total:						365.40
Family/Caregiver Training	Hours	4	2.25	40.60	365.40	
Medical Equipment Operating Expense Total:						7760.07
Medical Equipment Operating Expense	Months	31	5.27	47.50	7760.08	
Personal Emergency Response (PERS) Installation and Testing Total:						4065.00
Personal Emergency Response (PERS) Installation and Testing	Months	1	1.00	4065.00	4065.00	
Personal Emergency Response Systems (PERS) Total:						3885.98
Personal Emergency Response Systems (PERS)	Hours	14	6.77	41.00	3885.98	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						136625861.27
LVN	Hours	1748	2669.80	26.92	125630535.97	
CHHA	Hours	211	1191.01	18.90	4749628.78	
RN	Hours	164	1050.29	36.26	6245696.53	

GRAND TOTAL:	273005366.11
Total Estimated Unduplicated Participants:	6050
Factor D (Divide total by number of participants):	45124.85
Average Length of Stay on the Waiver:	328

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional Case Management Total:						**189579.26**
Transitional Case Management	Hours	114	40.96	40.60	**189579.26**	
			GRAND TOTAL:			**273005366.11**
			Total Estimated Unduplicated Participants:			**6050**
			Factor D (Divide total by number of participants):			**45124.85**
			Average Length of Stay on the Waiver:			328

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:						**516356.20**
Case Management	Quarter Hour	715	67.81	10.65	**516356.20**	
Habilitation Services Total:						**147205.04**
Habilitation Services	Quarter Hour	36	402.86	10.15	**147205.04**	
Home Respite Total:						**38104.25**
Home Respite	Quarter Hour	9	716.38	5.91	**38104.25**	
Waiver Personal Care Services (WPCS) Total:						**118076953.27**
Waiver Personal Care Services Regular Time	Hour	4385	1844.73	13.21	**106857553.27**	
Waiver Personal Care Services Overtime	Hour	1355	1440.00	5.75	**11219400.00**	
Community Transition Services Total:						**45738.00**
Community Transition Services	Event	77	1.00	594.00	**45738.00**	
Comprehensive Care Management Total:						**21235500.00**
Comprehensive Care Management	Monthly	6435	12.00	275.00	**21235500.00**	
			GRAND TOTAL:			**382739101.18**
			Total Estimated Unduplicated Participants:			**7150**
			Factor D (Divide total by number of participants):			**53529.94**
			Average Length of Stay on the Waiver:			328

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Continuous Nursing and Supportive Services Total:						**27142745.36**
Continuous Nursing and Supportive Services	Day	342	213.95	370.95	**27142745.36**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**10068653.20**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	73	326.74	422.13	**10068653.20**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**3367113.75**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	25	288.75	466.44	**3367113.75**	
Environmental Accessibility Adaptations Total:						**145000.00**
Environmental Accessibility Adaptations	Event	29	1.00	5000.00	**145000.00**	
Facility Respite Total:						**19792.71**
Facility Respite	Days	7	9.00	314.17	**19792.71**	
Family/Caregiver Training Total:						**456.75**
Family/Caregiver Training	Hours	5	2.25	40.60	**456.75**	
Medical Equipment Operating Expense Total:						**9262.02**
Medical Equipment Operating Expense	Months	37	5.27	47.50	**9262.02**	
Personal Emergency Response (PERS) Installation and Testing Total:						**4064.80**
Personal Emergency Response (PERS) Installation and Testing	Event	1	1.00	4064.80	**4064.80**	
Personal Emergency Response Systems (PERS) Total:						**4718.69**

GRAND TOTAL:	**382739101.18**
Total Estimated Unduplicated Participants:	**7150**
Factor D (Divide total by number of participants):	**53529.94**
Average Length of Stay on the Waiver:	328

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response Systems (PERS)	Months	17	6.77	41.00	4718.69	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						201850918.09
LVN	Hours	2066	2669.80	33.65	185606898.82	
CHHA	Hours	249	1191.01	23.63	7007748.01	
RN	Hours	194	1050.29	45.33	9236271.27	
Transitional Case Management Total:						66519.04
Transitional Case Management	Hour	40	40.96	40.60	66519.04	
				GRAND TOTAL:		382739101.18
				Total Estimated Unduplicated Participants:		7150
				Factor D (Divide total by number of participants):		53529.94
				Average Length of Stay on the Waiver:		328

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:						595795.61
Case Management	Quarter Hour	825	67.81	10.65	595795.61	
Habilitation Services Total:						171739.22
Habilitation Services	Quarter Hour	42	402.86	10.15	171739.22	
Home Respite Total:						44147.64
Home Respite	Quarter Hour	11	679.09	5.91	44147.64	
Waiver Personal Care Services (WPCS) Total:						148480224.73
Waiver Personal					134773339.93	
				GRAND TOTAL:		501163298.55
				Total Estimated Unduplicated Participants:		8250
				Factor D (Divide total by number of participants):		60747.07
				Average Length of Stay on the Waiver:		338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Services Regular Time	Hour	5059	1943.13	13.71		
Waiver Personal Care Services Overtime	Hour	1563	1440.00	6.09	13706884.80	
Community Transition Services Total:						52866.00
Community Transition Services	Event	89	1.00	594.00	52866.00	
Comprehensive Care Management Total:						24502500.00
Comprehensive Care Management	Monthly	7425	12.00	275.00	24502500.00	
Continuous Nursing and Supportive Services Total:						31349077.24
Continuous Nursing and Supportive Services	Day	395	213.95	370.95	31349077.24	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						12074114.71
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	84	326.74	439.92	12074114.71	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						4070479.88
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	29	288.75	486.10	4070479.88	
Environmental Accessibility Adaptations Total:						170000.00
Environmental Accessibility Adaptations	Event	34	1.00	5000.00	170000.00	
Facility Respite Total:						22620.24
Facility Respite	Days	8	9.00	314.17	22620.24	
Family/Caregiver Training Total:						548.10
Family/Caregiver Training	Hours	6	2.25	40.60	548.10	
Medical Equipment Operating Expense						10513.65

GRAND TOTAL:	501163298.55
Total Estimated Unduplicated Participants:	8250
Factor D (Divide total by number of participants):	60747.07
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Medical Equipment Operating Expense	Months	42	5.27	47.50	10513.65	
Personal Emergency Response (PERS) Installation and Testing Total:						4065.00
Personal Emergency Response (PERS) Installation and Testing	Event	1	1.00	4065.00	4065.00	
Personal Emergency Response Systems (PERS) Total:						5273.83
Personal Emergency Response Systems (PERS)	Months	19	6.77	41.00	5273.83	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						279531172.84
LVN	Hours	2384	2669.80	40.38	257010753.22	
CHHA	Hours	288	1191.01	28.35	9724358.45	
RN	Hours	224	1050.29	54.39	12796061.17	
Transitional Case Management Total:						78159.87
Transitional Case Management	Hours	47	40.96	40.60	78159.87	
				GRAND TOTAL:		501163298.55
				Total Estimated Unduplicated Participants:		8250
				Factor D (Divide total by number of participants):		60747.07
				Average Length of Stay on the Waiver:		338

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:						675235.03
				GRAND TOTAL:		578757303.97
				Total Estimated Unduplicated Participants:		9350
				Factor D (Divide total by number of participants):		61899.18
				Average Length of Stay on the Waiver:		348

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management	Quarter Hour	935	67.81	10.65	675235.03	
Habilitation Services Total:						192184.36
Habilitation Services	Quarter Hour	47	402.86	10.15	192184.36	
Home Respite Total:						51899.97
Home Respite	Quarter Hour	12	731.81	5.91	51899.97	
Waiver Personal Care Services (WPCS) Total:						179162768.36
Waiver Personal Care Services Regular Time	Hour	5734	1996.86	14.21	162704432.36	
Waiver Personal Care Services Overtime	Hour	1772	1440.00	6.45	16458336.00	
Community Transition Services Total:						59994.00
Community Transition Services	Event	101	1.00	594.00	59994.00	
Comprehensive Care Management Total:						27769500.00
Comprehensive Care Management	Monthly	8415	12.00	275.00	27769500.00	
Continuous Nursing and Supportive Services Total:						35476044.37
Continuous Nursing and Supportive Services	Day	447	213.95	370.95	35476044.37	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						13655248.78
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	95	326.74	439.92	13655248.78	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						4631925.38
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	33	288.75	486.10	4631925.38	
Environmental Accessibility Adaptations Total:						190000.00

GRAND TOTAL:	578757303.97
Total Estimated Unduplicated Participants:	9350
Factor D (Divide total by number of participants):	61899.18
Average Length of Stay on the Waiver:	348

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations	Event	38	1.00	5000.00	190000.00	
Facility Respite Total:						28275.30
Facility Respite	Days	10	9.00	314.17	28275.30	
Family/Caregiver Training Total:						548.10
Family/Caregiver Training	Hours	6	2.25	40.60	548.10	
Medical Equipment Operating Expense Total:						12015.60
Medical Equipment Operating Expense	Months	48	5.27	47.50	12015.60	
Personal Emergency Response (PERS) Installation and Testing Total:						4065.00
Personal Emergency Response (PERS) Installation and Testing	Event	1	1.00	4065.00	4065.00	
Personal Emergency Response Systems (PERS) Total:						6106.54
Personal Emergency Response Systems (PERS)	19	22	6.77	41.00	6106.54	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						316753355.46
LVN	Hours	2702	2669.80	40.38	291293227.85	
CHHA	Hours	326	1191.01	28.35	11007433.52	
RN	Hours	253	1050.29	54.39	14452694.09	
Transitional Case Management Total:						88137.73
Transitional Case Management	Hours	53	40.96	40.60	88137.73	
				GRAND TOTAL:		578757303.97
				Total Estimated Unduplicated Participants:		9350
				Factor D (Divide total by number of participants):		61899.18
				Average Length of Stay on the Waiver:		348

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:						712788.21
Case Management	Quarter Hour	987	67.81	10.65	712788.21	
Habilitation Services Total:						204451.45
Habilitation Services	Quarter Hour	50	402.86	10.15	204451.45	
Home Respite Total:						54001.50
Home Respite	Quarter Hour	13	702.87	5.91	54001.50	
Waiver Personal Care Services (WPCS) Total:						200648823.44
Waiver Personal Care Services Regular Time	Hour	6053	2046.92	14.71	182256999.44	
Waiver Personal Care Services Overtime	Hour	1870	1440.00	6.83	18391824.00	
Community Transition Services Total:						62964.00
Community Transition Services	Event	106	1.00	594.00	62964.00	
Comprehensive Care Management Total:						29317200.00
Comprehensive Care Management	Monthly	8884	12.00	275.00	29317200.00	
Continuous Nursing and Supportive Services Total:						37460163.18
Continuous Nursing and Supportive Services	Day	472	213.95	370.95	37460163.18	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						14373946.08
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	100	326.74	439.92	14373946.08	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						4772483.10
Developmentally					4772483.10	

GRAND TOTAL:	622448870.14
Total Estimated Unduplicated Participants:	9871
Factor D (Divide total by number of participants):	63058.34
Average Length of Stay on the Waiver:	358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	34	288.75	486.12		
Environmental Accessibility Adaptations Total:						**200000.00**
Environmental Accessibility Adaptations	Event	40	1.00	5000.00	**200000.00**	
Facility Respite Total:						**28275.30**
Facility Respite	Days	10	9.00	314.17	**28275.30**	
Family/Caregiver Training Total:						**639.45**
Family/Caregiver Training	Hours	7	2.25	40.60	**639.45**	
Medical Equipment Operating Expense Total:						**12766.58**
Medical Equipment Operating Expense	Months	51	5.27	47.50	**12766.58**	
Personal Emergency Response (PERS) Installation and Testing Total:						**4065.00**
Personal Emergency Response (PERS) Installation and Testing	Event	1	1.00	4065.00	**4065.00**	
Personal Emergency Response Systems (PERS) Total:						**6384.11**
Personal Emergency Response Systems (PERS)	Months	23	6.77	41.00	**6384.11**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**334496792.09**
LVN	Hours	2853	2669.80	40.38	**307572012.97**	
CHHA	Hours	344	1191.01	28.35	**11615205.92**	
RN	Hours	268	1050.29	54.39	**15309573.19**	
Transitional Case Management Total:						**93126.66**
Transitional Case Management	Hours	56	40.96	40.60	**93126.66**	

GRAND TOTAL:	**622448870.14**
Total Estimated Unduplicated Participants:	**9871**
Factor D (Divide total by number of participants):	**63058.34**
Average Length of Stay on the Waiver:	358