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:
Medi-Cal Waiver Program (MCWP)

C. Waiver Number:CA.0183
Original Base Waiver Number: CA.0183.

D. Amendment Number:CA.0183.R06.02

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

11/12/23

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

2. Purpose(s) of Amendment

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

The purpose of this amendment is to
1. Include telehealth as a permanent service delivery option for specified waiver services, in compliance with California Welfare and Institutions Code section 14132.725; federal statute and regulations; and as agreed upon by the applicant, participant, legal representative, and Medi-Cal provider.
2. Update language for a state-level “Social Work Consultant” to assist with Program Compliance Reviews (PCRs) and record review to state-level “Program Advisor.”
3. Update language for state-level nurses from “Nurse Consultant” to “Registered Nurse”

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	Additional Needed Information (Optional)
Appendix A Waiver Administration and Operation	A.6
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	D.1.g; D.2.b
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	G.1.b
Appendix H	
Appendix I Financial Accountability	I.1
Appendix J Cost-Neutrality Demonstration	

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other
Specify:

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

Modify requirements of state-level staff performing PCRs.

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*):

Medi-Cal Waiver Program (MCWP)

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.0183
Waiver Number:CA.0183.R06.02
Draft ID: CA.007.06.01

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

Regular Waiver

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

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

Hospital
Select applicable level of care

Hospital as defined in 42 CFR §440.10
If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

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:

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:

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 HIV/AIDS Medicaid Home and Community-Based Services Waiver (herein referred to as the Medi-Cal Waiver Program [MCWP]) is to provide enhanced case management and direct care services as an alternative to nursing facility care or hospitalization. Case management incorporates a collaborative interdisciplinary team approach consisting of a nurse and social work case manager, who work with the participant, their primary care provider, family, caregivers, and other service providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution.

The program enrolls individuals into home and community-based services who have a written diagnosis of HIV/AIDS, a health status stable enough to make home care appropriate, are eligible for Medi-Cal on date of enrollment and each month thereafter, and have been certified by a Registered Nurse (RN) to meet the Nursing Facility Level of Care (NF-LOC) as defined by Title 22, California Code of Regulations, Sections 51334 and 51335 prior to enrollment and at minimum 365 days thereafter. The goals are to:
• Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care;
• Increase coordination among service providers and eliminate duplication of services;
• Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and,
• Enhance utilization of the program by underserved populations.

The objectives of case management within the MCWP are to:
• Coordinate efficient use of community resources in a cost effective, high quality manner acceptable to the participant;
• Foster continuity of services throughout the continuum of care;
• Promote understanding by the participant and/or legal representative, family, and caregivers of the HIV disease process and the use of health promotion practices;
• Decrease the transmission of HIV through education/harm reduction techniques;
• Maintain quality health care along the continuum of illness;
• Decrease fragmentation of care; and
• Provide services through culturally and linguistically appropriate services.

The Department of Health Care Services (DHCS) serves as liaison to the federal Centers for Medicare and Medicaid Services (CMS) in fulfilling its role as California’s Single State Medicaid Agency (SSMA). DHCS’ Health Care Delivery Systems (HCDS)/Integrated Systems of Care Division (ISCD) oversees the monitoring and oversight of the implementation and administration of the Waiver. DHCS/HCDS/ISCD delegates administration of the programmatic components of the MCWP to the California Department of Public Health (CDPH) through an Interagency Agreement. CDPH/Office of AIDS (CDPH/OA) provides program oversight and monitoring, and reports to DHCS’ HCDS/ISCD.
CDPH/OA contracts directly with local agencies statewide to implement the MCWP. These agencies are known as Waiver agencies and subcontract with qualified providers to render direct care services and provide comprehensive nurse and social work case management.

3. Components of the Waiver Request

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

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

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

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

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

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

Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

F. **Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. **Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

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

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

The public comment period ended on July 30, 2023.

Tribal notice was not necessary for this amendment, as per an email correspondence sent to Stephanie Hockman, Coordinator, DHCS Indian Health Program, on June 26, 2023, from Cynthia Lemesh, CMS Native American Contact, approving DHCS' request for No Tribal Notice.
DHCS received a total of 30 Comments from 15 entities regarding the telehealth. The comments did not include any MCWP specific feedback. Major themes received in support are summarized below:

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

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

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

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

No changes to the telehealth amendment were made in response to public comments.

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

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

7. Contact Person(s)

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

Last Name: Maslyn

First Name: Cortney

Title: Integrated Systems of Care, Division Chief

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue

Address 2: P.O. Box 997413, MS 4502

City: Sacramento

State: **California**

Zip: 95899-7413

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

Fax: (916) 552-9660

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

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

Last Name: Halfman

First Name: Karl

Title: Chief, HIV Care Branch / Office of AIDS

Agency: California Department of Public Health

Address: MS 7700

Address 2: P.O. Box 997426

City: Sacramento

State: California

Zip: 95899-7426

Phone: (916) 449-5966 **Ext:** **TTY**

Fax: (916) 449-5959

E-mail: karl.halfman@cdph.ca.gov

8. Authorizing Signature

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

Signature: MICHELLE BAASS

State Medicaid Director or Designee

Submission Date: Oct 25, 2023

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

Last Name: Baass

First Name: Michelle

Title: Director & Interim State Medicaid Director

Agency: Department of Health Care Services

Address: 1501 Capitol Ave.

Address 2: MS 0000

City: Sacramento

State: California

Zip: 95899-7413

Phone:

(916) 440-7400 **Ext:** **TTY**

Fax:

(916) 440-7404

E-mail:

Michelle.baass@dhcs.ca.gov

Attachments

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

N/A

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

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

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

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

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

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

The state assures that this Waiver renewal will be subject to any provisions or requirements included in the State’s most recent and/or approved 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):

Comment 2: The salary for our staff and our contractors increases by COLA each year (just like social security: 0.0% in 2016; 0.3% in 2017; 2.0% in 2018; 2.8% in 2019; 1.6% in 2021; 1.3% in 2021). Our benefits provide needed health insurance and benefits for our staff. Medi-Cal (Medicaid) Perspective Payment System (PPS) rates increase by Medicare Economic Index (MEI) every year to help us assist with the cost of providing medical services to our patients (1.1* in 2016; 1.2% in 2017; 1.4% in 2018; 1.5% in 2019; 1.3% in 2020) accumulating to an inflationary increase of 7.3% during the past MCWP 6 year contract period. Costs continue to rise each year and MCWP reimbursement rates have not kept pace. Please consider increasing rates.

SR: Thank you for your review and feedback.

>>>>>

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

1. Participants must be allowed to choose to receive services, as identified in item #10 below, via telehealth or in-person.
2. Services provided via telehealth must meet the individual's needs, as included in their person-centered care plan.
3. The waiver service provider believes that the service being provided via telehealth is clinically appropriate based upon evidence-based medicine or best practices or both. Additionally, the telehealth service must meet the procedural definition of the Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) code associated with the service, as well as follow any additional guidance provided by DHCS (e.g., through the DHCS Provider Manual).
4. Services will only be provided via telehealth if the needs of the beneficiary can be met remotely. Telehealth must not replace direct care that can only be provided in-person. If waiver participants' needs cannot be met via telehealth, in-person assistance is required to support the waiver participants' health and safety.
5. Services provided via telehealth must be delivered in a way that respects the privacy of the individual, especially in the instances of toileting, dressing, etc.
6. Providing the service via telehealth must not prevent the facilitation of community integration as defined in 42 CFR 441.301(c)(4). Remotely delivered services can be provided to multiple individuals at one time (without sharing private health information), which presents individuals the opportunity to interact with others, while receiving services in their preferred delivery method.
7. The waiver service provider must inform the patient prior to the initial delivery of telehealth services about the use of telehealth and obtain consent from the individual for the use of telehealth as an acceptable mode of delivering health care services. If personal care is needed while telehealth was being provided, the individual and/or person supporting the individual would conduct personal care activities out of the line of sight of the telehealth provider, turn off video/audio communication during that time, or reschedule the telehealth visit. If the telehealth includes video cameras and/or monitoring devises, privacy must be protected. In instances where privacy cannot be secured by the individual, the telehealth provider would pause the telehealth service until confirming it was appropriate to resume.
8. Providing the service via telehealth must not impede, replace, or prevent the successful delivery of HCBS for individuals who need hands-on assistance/physical assistance.
9. Support must be provided to individuals who need assistance with using the technology required for the delivery of the HCBS via telehealth. The individual's person-centered planning team is responsible for determining the extent of training necessary for the individual to access their services remotely, and for ensuring that the necessary training is provided and understood by the individual or legal guardian. Family members may also be eligible for training, as appropriate, to support the provision of services if determined to be beneficial for the individual. If the individual is unable to properly utilize the technology, with or without assistance, then telehealth is not appropriate.
10. The following services can be provided via Telehealth, in alignment with the above requirements:

•Psychotherapy
•Enhanced Case Management
•Nutritional Counseling

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:

(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:

California Department of Public Health

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:

DHCS serves as the SSMA in exercising administrative authority over the MCWP and serves as the primary liaison with CMS. Through an Interagency Agreement (IA) with DHCS, CDPH/OA administers the programmatic component of the MCWP, under DHCS/HCDS/ISCD monitoring, oversight, and administrative discretion, and according to federal and state statutes and regulations. DHCS/HCDS/ISCD and CDPH/OA maintain a formal system to monitor quality control, provider standards, plans of care, and services provided to participants to help ensure the health and welfare needs of individuals served under the MCWP are continuously met and protected. The Scope of Work and all associated exhibits to the IA are reviewed and updated by DHCS and CDPH/OA on an as-needed basis. Pursuant to subdivision (d) of California Welfare & Institutions Code Section 14000.03, the term of this IA remains in effect indefinitely, and all agreed upon revisions and updates are completed via contract amendment.

Functions delegated to CDPH/OA include:
• Provide MCWP services to Medi-Cal members with HIV/AIDS who would otherwise be institutionalized;
• Assure participant enrollment does not exceed the statewide enrollment capacity as identified in the MCWP;
• Ensure that Medi-Cal members who receive MCWP services meet the nursing facility or hospital level of care;
• Maintain separate contracts with each MCWP agency;
• Provide training and technical assistance to MCWP agencies and identify deficient areas of program administration;
• Serve as the central point of contact for MCWP agencies;
• Develop and promulgate all policies, procedures, and related memoranda regarding the MCWP;
• Maintain adequate safeguards and standards as set forth in the MCWP for providers that perform services under the MCWP;
• Perform MCWP agency program compliance reviews in accordance with the MCWP including monitoring and oversight of level of care, PCSPs, providers, administrative authority, and participant health and welfare; and,
• Perform financial monitoring and oversight of MCWP agencies including MCWP agencies fiscal policies and procedures.

DHCS/HCDS/ISCD administrative oversight activities include:
• Serve as liaison with CMS;
• Provide technical assistance and policy consultation to CDPH/OA (e.g., Medi-Cal program data, changes to the Medi-Cal program, cost neutrality);
• Resolve policy and system issues in accordance with CMS requirements, state laws, and regulations;
• Prepare expenditure reports for CMS;
• Review other required deliverables for submission to CMS (e.g., quarterly and annual reports);
• Meet, in collaboration with CDPH/OA, with stakeholders, advocacy groups, private insurers, local governments, and other state agencies to address emerging issues;
• Provide oversight for the MCWP amendments and renewals;
• Provide updates to CDPH/OA regarding DHCS/HCDS/ISCD staffing changes and assigned duties;
• Oversee the fiscal administration of the MCWP agencies, appropriateness of expenditures and financial reporting;
• Ensure overall cost neutrality of the MCWP; and
• Oversee MCWP agency payments through the State Fiscal Intermediary and provides payment data to CDPH/OA on an as-needed basis.

DHCS/HCDS/ISCD shall conduct annual provider site visits in collaboration with CDPH/OA to review:
o Eligibility;
o Necessity of services;
o Appropriateness of services;
o Appropriate problem follow-up;
o Level of care determinations;
o Timelines and appropriateness of assessments and reassessments; and
o Timelines of Notices of Action.

DHCS/HCDS/ISCD shall also review Program Compliance Review Reports and Corrective Action Plans (CAP).

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.:*

Contracted Entities
Home health agencies, outpatient departments of hospitals licensed and certified by the State, and community-based organizations perform operational and administrative activities/ functions through contractual agreements with CDPH/OA.

These entities must meet CDPH/OA performance standards and requirements, including the demonstrated organizational, administrative and financial capabilities to carry out the contractual responsibilities of a waiver.

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:

County Public Health Departments perform MCWP operational and administrative activities/functions through contractual agreements with CDPH/OA. These entities must meet CDPH/OA performance standards and requirements, including the demonstrated organizational, administrative and financial capabilities to carry out the contractual responsibilities of a 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:

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:

California Department of Public Health, Office of AIDS, HIV Care Branch, Special Programs Section.

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:

CDPH/OA is responsible for administering and monitoring the programmatic components of the MCWP. CDPH/OA reports results from monitoring activities to DHCS/HCDS/ISCD.

In accordance with 42 Code of Federal Regulations (CFR) 431.10, DHCS/HCDS/ISCD, as California's single State Medicaid Agency, delegates eligibility determinations to CDPH/OA. DHCS/HCDS/ISCD provides oversight to ensure that eligibility determinations comply with all Federal and State laws and relevant regulations and policies.

CDPH/OA maintains a formal system to monitor quality control, provider standards, participant centered care service plans, and services provided to participants to help ensure the health and welfare needs of individuals served under the MCWP are continuously met and safeguarded. The monitoring includes conducting onsite program compliance reviews (PCR), and review and evaluation of prior PCR summaries, review of provider quality assurance/quality improvement (QA/QI) plans, progress reports, paid claims data, and collection of federally-required fiscal audits. CDPH/OA reports monitoring results to DHCS/HCDS/ISCD.

PCR:
A CDPH/OA team, consisting of a Registered Nurse and Program Advisor, conducts a comprehensive PCR of each MCWP agency at least once every 24 months. A pre-determined portion of PCRs (frequency is determined annually by DHCS/HCDS/ISCD) are conducted in collaboration with a DHCS/HCDS/ISCD Nurse Evaluator II. The PCR consists of a contract monitoring component and participant record review component.

The contract monitoring component reviews and evaluates:
• Subcontracts and subcontractors' requirements;
• Caseload requirements;
• Provider licensure and qualification requirements;
• Written policies and procedures; and
• Fiscal requirements.

The participant record review component reviews and evaluates:
• MCWP eligibility including appropriate level of care assessments;
• Consent forms;
• Necessity and appropriateness of services;
• Timeliness and appropriateness of assessments, reassessments, PCSPs;
• Appropriate notice of action when applicable;
• Appropriate follow-up on participant grievances; and
• Appropriateness of payment for services delivered.

Provider QA/QI Review:
CDPH/OA requires MCWP agencies to implement a QA/QI program using CDPH/OA established guidelines to continually evaluate and improve the quality of services provided. MCWP agencies submit an annual QA/QI plan and a summary of QA/QI monitoring results to CDPH/OA semi-annually. MCWP agencies survey participants for satisfaction as part of their QA/QI activities and are required to submit summaries of the survey results to CDPH/OA for review. If CDPH/OA discovers problems or issues, CDPH/OA shall provide technical assistance to the MCWP agency. MCWP agencies shall include any issue or problem discovered by CDPH/OA for review on the subsequent QA/QI monitoring plan(s). CDPH/OA reviews these problems and/or issues during subsequent PCR, or as warranted.

Progress Reports Review:
MCWP agencies are required to submit progress reports bi-annually to CDPH/OA. The progress report provides monitoring information including: number of participants served by county, subcontractors, and types of contracted services, key staff and service providers' information (including licensure and/or certifications, and training), trends and barriers, participant grievances/requests for State Fair Hearings, risk assessment and mitigation, and technical assistance needs. CDPH/OA staff reviews and evaluates the progress reports and follows up with MCWP agencies to provide technical assistance and guidance as needed.

Fiscal Audits Review:
Annually, MCWP agencies are required to submit copies of fiscal audits as set forth in the United States Office of Management Budgets, 2 CFR Part 200 Uniform Guidance or in the California Health and Safety Code §§38040 – 38041 to CDPH/OA. Submission of these audits must be within the timeframes also set forth by these requirements. Per an

Interagency Agreement, DHCS Audits & Investigations periodically conducts audits on CDPH/OA contracts with MCWP agencies and will request fiscal audit documentation housed by CDPH/OA as part of the overall audit.

Oversight of CDPH/OA by DHCS/HCDS/ISCD:
Through an Interagency Agreement, DHCS/HCDS/ISCD is responsible for the monitoring and oversight of the CDPH/OA programmatic operation and administration, and fiscal accountability of the MCWP and MCWP agencies. Monitoring and oversight includes:
• Ensuring MCWP services are provided in accordance with Medicaid statute, Federal and State regulations, the CMS approved Waiver and IA requirements;
• Ensuring CDPH/OA's eligibility determinations comply with all Federal and State law and relevant regulations and policies.
• Reviewing and monitoring QA/QI plans and reports, statewide MCWP enrollment capacity, recipient data, and MCWP agencies operations;
• Reviewing MCWP policies, procedures, regulations (where applicable), documents, and other reports as necessary to align with Federal and State statutes and regulations;
• Developing and maintaining DHCS/HCDS/ISCD monitoring and oversight protocols;
• Identifying reporting requirements;
• Conducting on-site visits and/or desk reviews of MCWP agencies independently and/or jointly with CDPH/OA. Independent reviews may be conducted in the time and manner designated by DHCS/HCDS/ISCD; and
• Reviewing CAPs and monitoring their implementation. CAP reviews shall include, but are not limited to, a review of correspondence and supportive evidence that the areas of noncompliance have been resolved and the CAP implemented successfully.

In accordance with Provision 3, Paragraph A Section 3d of this exhibit, referring MCWP agency fiscal and/or programmatic irregularities/misconduct to DHCS A&I include;
• Notifying and submitting report of findings to CDPH within 30 days of receiving final report;
• Discussing review of findings and recommendations as necessary with CDPH/OA; and
• Providing corrective notice to CDPH/OA when necessary to ensure compliance with the provision of MCWP services according to Section 1915(c) of the Social Security Act.

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	Other State Operating 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				

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
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 Required quarterly oversight and coordination meetings conducted between CDPH/OA and Medicaid agency (DHCS) Numerator: Number of oversight and coordination meetings conducted/Denominator: Total number of planned oversight and coordination meetings

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100%**

		Review
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
#/% of Medicaid agency (DHCS) review of Summary of Findings Reports generated by CDPH/OA Numerator: Number of Summary of Findings Reports reviewed by Medicaid agency/Denominator: Total number of Summary of Findings Reports generated by CDPH/OA

Data Source (Select one):
Other
If 'Other' is selected, specify:
CDPH/OA provides copies of all Summary of Findings reports to the State Medicaid Agency

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

Data Aggregation and Analysis:

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

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

Performance Measure:
#/% of Policies/procedures issued by the CDPH/OA that have been reviewed and approved by the Medicaid agency prior to implementation. Numerator: Number of policies/procedures reviewed and approved by the Medicaid agency/Denominator: Total number of policies/procedures issued by CDPH/OA

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
#/% of contracts between CDPH/OA and MCWP agencies which meet the specifications set forth by this waiver. Numerator: Number of contracts between CDPH/OA and MCWP agencies, reviewed by DHCS, which meet the specifications set forth by this waiver. Denominator: Total number of contracts between CDPH/OA and MCWP Agencies reviewed by DHCS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CDPH/OA contracts submitted to DHCS

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: Ad hoc	

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):*
	Ad hoc

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.

N/A

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.

CDPH/OA works collaboratively with the Waiver Agency's Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the Waiver Agency during the exit conference, and a formal written Summary of Findings is provided to the Waiver Agency following the review. The Waiver Agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to verify the Waiver Agency appropriately addresses the findings.

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	0		
		Medically Fragile			
		Technology Dependent			
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 in a target group must:
• Be eligible under any of the Title XIX State Plan approved categorically needy or medically needy coverage groups for the full scope of State Plan services.
• Would otherwise require nursing facility or hospital level of care.
• Have a written diagnosis of HIV disease or AIDS from their primary care provider. For pediatric participants under 13 years of age, the written diagnosis is documented on the Centers for Disease Control and Prevention (CDC) Classification System for HIV in Children Under 13 Years of Age form. For individuals 13 years of age and over, the written diagnosis is documented on the MCWP Certification of Eligibility form;
• Not be simultaneously enrolled in the Medi-Cal Hospice Program (may be simultaneously enrolled in Medicare Hospice);
• Not be simultaneously enrolled in another Medi-Cal Home and Community-Based Services Waiver;
• Not be simultaneously receiving State Plan case management services or Targeted Case Management to supplement MCWP;
• Be certified to meet the NF LOC or the Acute Level of Care as described in Title 22, California Code of Regulations, Sections 51120, 51120.5, 51121, 51124, 51215, 51334 and 51335;
• Score at 60 or less on CDPH/OA's Cognitive Functional Ability (CFA) scale if over 13 years of age.

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 State does not refuse home or community-based services to any participant even though the State may reasonably expect the cost of services to exceed the individual cost limit specified by the State. The State provides home or community-based services to any otherwise eligible participant up to the maximum allowable amount as indicated by the State specified individual cost limit.

The State has recalculated the cost limit by using the average annual cost per person of the 2019 annual NF-A ($34,760) and NF-B ($84,902) costs. The average cost per person for NF-A and NF-B is $59,831 per year. In addition, MCWP participants receive Long Term Support Services (LTSS) through the State Plan, primarily In-Home Supportive Services at an annual average cost of $25,894; therefore, the State is deducting the individual cost amount for State Plan covered LTSS, i.e., IHSS, from the MCWP's individual cost limit. The new cost limit is $33,937. The State calculates this cost limit as the average costs necessary to provide Waiver services to the target population.

At the time of MCWP enrollment, participants sign an Informed Consent/Agreement to Participate document through which they are informed of the individual cost limit of $33,937 per MCWP year and by which all participants, upon reaching this limit, are disenrolled from the MCWP. Upon disenrollment, participants receive information about the State Fair Hearing process. Information on other resources within the community is provided to assist in the continued health and welfare of the participant.

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

The following dollar amount:

Specify dollar amount: 33937

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)

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:

Prior to enrollment, MCWP case managers conduct a comprehensive assessment of the applicant to determine service needs. Case managers, with participant's input, develop a Participant Centered Service Plan (PCSP) delineating how participant's needs are to be met and the funding source for all services. Of the services identified, only those services which exist in addition to State Plan services, other services, and supports, and which are used as the payer of last resort may be provided to a participant under the MCWP. Participants receive services under the MCWP based on need until individual cost cap is reached. When the cost cap is reached, the participant is disenrolled from the MCWP and informed of their right to request a State Fair Hearing. When a participant is disenrolled from the MCWP, they may be enrolled in the Ryan White HIV/AIDS Program (RWHAP) or provided services from other available funding sources to help safeguard the continued health and welfare of the participant. As long as the participant remains eligible for Medi-Cal, the participant will continue to receive all of the Medi-Cal State Plan services they were eligible to receive while enrolled in the MCWP. The scope of services provided by other funding sources may differ from MCWP services.

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:

If an MCWP participant maximizes their individual cost limit, as indicated above, they are provided a Notice of Action (NOA) 10 days prior to being disenrolled from the MCWP, and Notice of the Right to File a State Fair Hearing within 90 days of the date of the NOA. The participant is informed of other options, linked to other programs in the agency (such as RHWAP), and referred are made to other services in the community to address the health and welfare of the participant. At the beginning of the subsequent calendar year, if the individual is still eligible for the MCWP, they may be reenrolled.

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	1948
Year 2	1948
Year 3	1948
Year 4	1948
Year 5	1948

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	
Year 2	
Year 3	
Year 4	
Year 5	

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).

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:

The MCWP provides for the entrance of all eligible persons up to the capacity of the MCWP as long as there is a MCWP agency serving an applicant's county of residence, and available slots within the MCWP agency. When capacity is reached, entrance to the MCWP of otherwise eligible applicants will be deferred until capacity becomes available. The State may submit a Waiver amendment to CMS to modify the number of participants specified for any year(s) where the capacity is reached.

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 435.110, pregnant women specified at 435.116 and children specified at 435.118, and any who would otherwise be eligible for SSI/SSP as provided in Section 1902(a)(10)(A)(ii)(I), including those who are eligible under section 1634(a)(c) and (d).

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:

Other

Specify:

The maximum amount allowed when determining eligibility for the individual under the State Plan, which is the sum of (1) the income standards that the state used to determine eligibility and (2) any amounts disregarded during the Section 1902 (a) (10)(A)(ii) eligibility phase.

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:

The amount which represents the sum of (1) the income standards that the state used to determine eligibility and (2) any amounts disregarded during the Section1902 (a)(10)(A)(ii) eligibility phase.

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

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

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

Nurse Case Manager: RN licensed by the State of California who has two years of experience as an RN, with at least one year in community nursing. It is desirable, but not mandatory, that the RN Case Manager has obtained a Bachelor of Science degree in Nursing (BSN), and has a Public Health Nurse (PHN) certificate.

Social Work Case Manager: An individual licensed by the State of California as a Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist, or Psychologist, or an individual with a Master's Degree in Social Work, Counseling, or Psychology. An individual may have a Bachelor's degree in Social Work, Psychology, Counseling, Rehabilitation, or Sociology and at least one-year experience in case management.

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.

• Nursing Facility Level of Care, Title 22, California Code of Regulations, Sections 51334 and 51335
• Nursing and psychosocial assessments
• Adults scored at 60 or less on CDPH/OA's Cognitive Functional and Ability (CFA) scale

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 Nursing Facility Level of Care and assessments/reassessments, the MCWP agency uses the CFA scale to summarize the participant's condition. The CFA scale was developed to adapt the Karnofsky Performance Scale to be more specific to adults with HIV or AIDS. The CFA scale is based on the findings of the Nursing Assessment and Psychosocial Assessment and produces a numerical score. Individuals must have a CFA score of 60 or less to be eligible for the MCWP. This level of care instrument used by the MCWP is different because it includes additional assessments categories specific to HIV/AIDS. The same criteria are used for both the MCWP and the institution, so the outcomes are equivalent.

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:

Assessments - All applicants are screened for eligibility and receive face-to-face comprehensive assessments by qualified case managers who meet the State's licensing and other program requirements. The level of care evaluation process includes:
• Nursing Assessment on or within 15 days prior to enrollment. This assessment includes a comprehensive medical review and also identifies participant's care needs, evaluates participant's health condition, and risk and history of abuse. It also assists with formulation of the PCSP and with coordination of care;
• NF LOC Certification on or within 15 days prior to enrollment per Title 22 of the California Code of Regulations, sections 51134 and 51335;
• Psychosocial Assessment on or within 15 days prior to enrollment. This assessment provides information about participant status in the following areas: social, emotional, behavioral, mental, spiritual, legal, financial, environmental, and risk and history of abuse. It also assists with formulation of the PCSP and with coordination of care;
• CFA scale scoring of 60 or below on or within 15 days of enrollment; and
• Reassessments – All applicants receive face-to-face comprehensive Nursing and Psychosocial reassessments by qualified case managers at least every 365 days or as warranted by changes in participant's condition, which include CFA scoring. Family members, caregivers, or a participant's legal representative may request a timelier review, if necessary.
• A state-level RN, employed by CDPH/OA, reviews, approves, and processes all LOC determinations submitted by contracted agencies.

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:

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):*

Reassessments are an integral part of the case management services performed by qualified case managers every 365 days. During the MCWP agency PCR, which occur at least once every 24 months, CDPH/OA and DHCS/HCDS/ISCD review participant files to determine if reassessments are complete, accurate, and timely. On the last day of the PCR, CDPH/OA staff identify areas requiring correction and provide feedback and technical assistance with key MCWP agency staff. Within 30 days of completing the PCR, CDPH/OA sends a written report to the MCWP agency in which findings and any areas requiring corrective action are identified. When corrective action is needed, the MCWP agency must submit a CAP to CDPH/OA within 30 days of receipt of CDPH/OA's written report. At the subsequent compliance review, CDPH/OA and DHCS/HCDS/ISCD review the areas where findings and corrective action were required. Based on its review, CDPH/OA discusses strengths and areas needing improvement with MCWP agency staff and provides technical assistance as necessary. MCWP sites have various methods to ensure timely LOC re-evaluations, such as: Excel spreadsheets that calculate all LOC re-evaluations due in the next month, care management system tickler files, and care management team meetings to validate this information.

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:

MCWP agencies must follow the guidelines outlined in the MCWP agency contract for record handling and documentation practices for health care records. Participant service records, including initial assessments and reassessments, must be:

• Kept in writing or an electronically-retrievable form at each MCWP agency. The MCWP agency is responsible for the maintenance of waiver participant case documentation and records which support the claims for waiver services for a minimum period of ten years after the participant is receiving billable waiver services, or from the date of completion of any audit, whichever is later.
• Kept in a locked storage area accessible only to MCWP agency staff directly responsible for filing, charting, and reviewing, and State and Federal representatives, as required by law; and
• Protected from potential damage.

No documents shall be destroyed or removed from a record once entered. MCWP agencies must maintain a plan for record storage and retrieval if the organization were to close. Policies must meet the minimum requirements as outlined in the MCWP agency contract, for record handling and documentation practices for health care records as established for MCWP agencies.

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:
#/% of MCWP participants who received a Level of Care evaluation Numerator: Number of MCWP participants who received a Level of Care evaluation/Denominator: Total number of participant records reviewed

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

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: Biennially	

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: Biennially

Performance Measure:
#/% of applicants for whom there is reasonable indication that services may be needed who received a LOC evaluation Numerator - Number of applicants for whom there is reasonable indication that services may be needed and received a LOC evaluation Denominator - Total number of applicants for whom there is reasonable indication that services may be needed.

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

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: Biennially

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:
#/% of MCWP participant's Level of Care determinations that were completed by a qualified provider Numerator: Number of Level of Care determinations completed by a qualified provider/Denominator: Total number of participant records reviewed

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

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: Biennially	

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: Biennially

Performance Measure:
#/% of Level of Care determinations completed on approved Level of Care tools (Nursing assessment and Cognitive and Functional Ability score) out of the total number of records reviewed Numerator: Number of Level of Care determinations completed on approved Level of Care tools/Denominator: Total number of participant records reviewed

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

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: Biennially	

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: Biennially

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.

N/A

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.

CDPH/OA works collaboratively with the MCWP agency's Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the MCWP agency during the exit conference, and a formal written Summary of Findings (SOF) is provided to the MCWP agency following the review. The MCWP agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the MCWP agency appropriately addresses the findings.

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).

When an individual is determined eligible for the MCWP, the MCWP case managers describe MCWP services, limitations, requirements, and any feasible alternative programs. The individual and/or their legal representative is then given the choice between the MCWP and other care/institutionalization. The Informed Consent/Agreement to Participate, Participant's Rights in Case Management, Grievance Policy, and MCWP Notice of Action: Your Right to a State Fair Hearing forms are reviewed with the participant and/or legal representative and questions are answered. If MCWP services are chosen, the individual signs the Informed Consent/Agreement to Participate form, initialing and dating acknowledgment and receipt of participant's rights and responsibilities, grievance procedures, and Notice of Action information.

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.

All initial enrollment forms are maintained for a minimum of three years from the date of final payment under the contract and kept in the participant's service record stored at each MCWP agency.

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):

MCWP agencies make every effort to assure access to oral and written assistance to Limited English Proficient (LEP) persons. CDPH/OA requires MCWP agencies to:

• Conduct community outreach to reach populations and/or groups in the community who are institutionalized or disproportionately affected by HIV/AIDS, and provide meaningful access to services for all persons, including those with LEP;

• Provide meaningful access to bilingual service providers and interpreter services for participants whose ability to speak and/or understand English is limited; and

• MCWP required participant forms are available in English and Spanish, i.e., Informed Consent/Agreement to Participate, Authorization to Exchange Confidential Information, Participant Rights in Case Management, and Notice of Action: Request for a State Fair Hearing. Currently, CDPH/OA is unaware of current need for participant forms in other languages; however, if a need arises, CDPH/OA will have the forms translated.

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	Enhanced Case Management
Extended State Plan Service	Homemaker
Extended State Plan Service	Skilled Nursing, Licensed Vocational Nurse
Extended State Plan Service	Skilled Nursing, Registered Nurse
Other Service	Attendant Care
Other Service	Home-Delivered Meals / Nutritional Supplements
Other Service	Medi-Cal Supplements for Infants and Children in Foster Care
Other Service	Minor Physical Adaptations to the Home
Other Service	Non-Medical Transportation
Other Service	Nutritional Counseling
Other Service	Psychotherapy
Other Service	Specialized Medical Equipment and Supplies

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):

Enhanced 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:**

Enhanced Case Management consists of identifying service needs, locating, coordinating and supervising services rendered to persons with a diagnosis of HIV/AIDS, in accordance with identified needs as set forth in a written PCSP and in consideration of the participant’s health and welfare. Enhanced Case Management assists participants in connecting to needed services, regardless of funding source. This service is primarily for the benefit of the MCWP participant.

Enhanced Case Management is a collaborative and interdisciplinary approach performed by a team consisting of a Social Work Case Manager (SWCM), Registered Nurse Care Manager (RNCM), Primary Care Provider, participant or legal representative and parent or guardian of a child enrolled in the MCWP.

The Case Management team provides the following components of Enhanced Case Management: assessment of MCWP participant needs, as well as needed medical, behavioral health, social, and other services; level of care certification; PCSP development including service authorization and implementation, coordination, and monitoring; ongoing MCWP participant contact (including a monthly, at minimum, face to face visit or telephone call; quarterly face-to-face visits [face to face visits may be conducted by the RNCM and/or SWCM as warranted by identified medical and/or psychosocial needs]; level of care recertification no later than 365 days of the last level of care evaluation; annual case management team reassessment of the participant; and an annual PCSP update. All activities can occur more frequently should the MCWP participant’s situation warrant it.

Enhanced Case Management assists MCWP participants in accessing needed MCWP and other State Plan services, as well as needed medical, behavioral health, social, and other services, allowing the MCWP participant freedom of choice, regardless of the funding source. Case Managers are responsible for ongoing monitoring of the provision of services included in the MCWP participant's PCSP. Additionally, case managers initiate and oversee the process of assessment and reassessment of MCWP participant level of care and the monthly review of PCSPs. MCWP agencies are responsible for assessing, developing PCSPs, locating, authorizing, coordinating, and monitoring a package of long-term care services and supports for MCWP participants. The teams are responsible for case management services including: the assessment; care plan development; service authorization and delivery; monitoring and follow up components of the program, including assessing medical and behavioral healthcare needs and providing referrals as warranted. Both the RNCM and SWCM professionals are fully utilized in carrying out the various case management functions. Case records must document all MCWP participant contact activity each month.

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

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

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

MCWP agencies’ case management services are reimbursed a monthly flat fee per participant for enrolled participants.

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	Registered Nurse (RN) Case Manager

Provider Category	Provider Type Title
Agency	Social Work Case Manager

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Enhanced Case Management

Provider Category:

Agency

Provider Type:

Registered Nurse (RN) Case Manager

Provider Qualifications

License *(specify):*

California Code of Regulations (CCR), Title 16, Section 1409, Nursing Practice Act, Division 2, Chapter 6, Article 1, Section 2732

Certificate *(specify):*

N/A

Other Standard *(specify):*

Two years of experience as an RN, with at least one year in community nursing. A Bachelor of Science degree in Nursing and a Public Health Nurse certificate is desirable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Consumer Affairs, Board of Registered Nursing

Frequency of Verification:

Every two years

Prior to/at time of employment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Enhanced Case Management

Provider Category:

Agency

Provider Type:

Social Work Case Manager

Provider Qualifications

License *(specify):*

LCSW
CCR, Title 16, Division 18 and Business and Professions Code (BPC) Division 2, Chapter 14, Articles 1-4, Sections 4990-4998.7
or
Marriage and Family Therapist:
CCR Title 16, Division 18 and BPC Chapter 13, Article 1-7, Sections 4980-4989
or
Psychologist:
CCR, Title 16, Division 13.1 and BPC, Chapter 6.6, Section 2903

Certificate *(specify):*

N/A

Other Standard *(specify):*

An individual licensed by the State of California as a LCSW, Marriage and Family Therapist, or Psychologist, or an individual with a Master's Degree in Social Work, Counseling, or Psychology. An individual may have a Bachelor's degree in Social Work, Psychology, Counseling, Rehabilitation, or Sociology and at least one-year experience in case management.

Verification of Provider Qualifications

Entity Responsible for Verification:

LCSW:
Department of Consumer Affairs, Board of Behavioral Sciences Project Director or Personnel Office at the MCWP agency.

Marriage and Family Therapist,
Department of Consumer Affairs, Board of Behavioral Sciences Project Director or Personnel Office at the MCWP agency.

Psychology
Department of Consumer Affairs, Board of Psychology
Project Director or Personnel Office at the MCWP agency

Master of Social Work, Counseling, or Psychology or Bachelor's Degree in Social Work, Psychology, Counseling, Rehabilitation or Sociology, as approved by CDPH/OA Or an individual may have a Bachelor's degree in Social Work, Psychology, Counseling, Rehabilitation or Sociology and at least one year experience in case management.

Frequency of Verification:

Licensed Clinical Social Worker: Every two years
Prior to/at time of employment

Marriage and Family Therapist Every two years
Prior to/at time of employment

Psychologist Every two years
Prior to/at time of employment

Master of Social Work, Counseling, or Psychology or Bachelor's Degree in Social Work, Psychology, Counseling, Rehabilitation or Sociology, as approved by CDPH/OA Or an individual may have a Bachelor's degree in Social Work, Psychology, Counseling, Rehabilitation or Sociology and at least one year experience in 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:

Extended State Plan Service

Service Title:

Homemaker

HCBS Taxonomy:

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

Service Definition *(Scope)*:

Homemaker services consist of general household activities performed when an individual who is regularly responsible for these activities is temporarily absent or unable to manage the home, or care for him/herself or others in the home. These services allow individuals to continue to live independently.

Services rendered are in addition to, not in place of, services authorized under the Medi-Cal State Plan, the In-Home Supportive Services (IHSS) 1915(j) option, 1915(k) Community First Choice, and the Personal Care Services Program.

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

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

Homemaker services are provided to participants whose needs exceed the maximum amount available under the State Plan. The need, quantity, frequency, and duration for services will be determined by the qualified case manager as part of their regular assessments and reassessments.

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	Home Health Agency
Agency	Private Nonprofit or Proprietary Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725

Certificate *(specify):*

N/A

Other Standard *(specify):*

As specified in the California Department of Social Services Manual of Policies and Procedures,
Must provide basic training on HIV/AIDS, infection control, confidentiality, and Abuse, Neglect and Exploitation.
The MCWP agency provides this service directly when an exemption has been approved by CDPH/OA

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification and the MCWP agency site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency

Provider Qualifications

License *(specify):*

Local California business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

As specified in the California Department of Social Services Manual of Policies and Procedures,
Must provide basic training on HIV/AIDS, infection control, confidentiality, and Abuse, Neglect and Exploitation.
The MCWP agency provides this service directly when an exemption has been approved by CDPH/OA

Verification of Provider Qualifications

Entity Responsible for Verification:

MCWP agency Project Director and CDPH/OA as appropriate

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Skilled Nursing, Licensed Vocational Nurse

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:**

Skilled nursing services consist of:
• Assessing and assisting in evaluating participants' nursing needs related to specific skilled home care;
• Implementing the home health agency nursing plan of care;
• Performing treatments and instituting preventive procedures in accordance with the plan of treatment or the plan of care that require the special skills of a nurse, as ordered by a physician and/or as authorized by the qualified case manager;
• Performing rehabilitative procedures, as appropriate, that are required for the safety and care of the participant;
• Monitoring participant symptoms and reporting change/client participant needs to treating physician and the qualified case manager;
• Counseling and instructing the participant and family about nursing and related needs; and
• Preparing clinical assessment and progress notes related to the above functions.

In addition to the above mentioned services, the Licensed Vocational Nurse may also provide the following services:
• Provision of basic hygienic and nursing care;
• Measurement of vital signs;
• Basic participant assessment (collection of information, not interpretation of information);
• Participates in planning;
• Executes interventions in accordance with the care plan or treatment plan;
• Contributes to evaluation of individualized interventions related to the care plan or treatment plan;
• Administer prescribed medical treatments;
• Administration of prescribed medications;
• Performance of non-medicated intravenous therapy and blood withdrawal (requires separate Board certification);
• Provides patient/participant care and education; and
• Contributes to the development and implementation of a teaching plan related to self-care for the patient/participant.

Services are provided when nursing services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amounts of services that may be provided through the MCWP also include: (1) end-stage continuous short-term care for participants not electing the hospice benefit, and (2) continuous care situations (State plan is primarily for intermittent care).

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

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

Services will be paid for based on 15-minute increment rate and the frequency and need for services will be determined by the qualified case manager. State plan services will be used when available.

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	Waiver Agency with Exemption Approved by CDPH/OA
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing, Licensed Vocational Nurse

Provider Category:
Agency
Provider Type:

Waiver Agency with Exemption Approved by CDPH/OA
Provider Qualifications
License *(specify):*

Business and Professions Code Sections 144, 480-487, 492, 493, 496, 810, 820-828, 2866, and 2872.1.
Certificate *(specify):*

Other Standard *(specify):*

CDPH/OA approved exemption.
Verification of Provider Qualifications
Entity Responsible for Verification:

Waiver agency project director and CDPH/OA
Frequency of Verification:

Prior to/at time of hire and every 12 months thereafter.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing, Licensed Vocational Nurse

Provider Category:
Agency
Provider Type:

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

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725
Certificate *(specify):*

N/A

Other Standard *(specify)*:

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification and the MCWP agency Project Director.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Skilled Nursing, Registered Nurse

HCBS Taxonomy:

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

Service Definition *(Scope)*:

Skilled nursing services consist of:
- Assessing and evaluating participants' nursing needs related to specific skilled home care;
- Developing and implementing the home health agency nursing plan of care;
- Evaluating and treating ailments and instituting preventive procedures that require the special skills of a nurse, as ordered by a physician and/or as authorized by the qualified case manager;
- Performing rehabilitative procedures, as appropriate, that are required for the safety and care of the participant;
- Monitoring participant symptoms and reporting change/participant needs to treating physician and the qualified case manager;
- Counseling and instructing the participant and family about nursing and related needs; and
- Preparing clinical assessment and progress notes related to the above functions.

In addition to the above mentioned services, the Registered Nurse may also provide the following services:
- Medication management;
- Drawing insulin;
- Injections; and
- Dressing changes.

Services are provided when nursing services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the State plan. The provider qualifications specified in the State Plan apply. The additional amounts of services that may be provided through the MCWP also include: (1) end-stage continuous short-term care for participants not electing the hospice benefit, and (2) continuous care situations (State plan is primarily for intermittent care).

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

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

Services will be paid for based on 15-minute increment rate and the frequency and need for services will be determined by the qualified case manager. State plan services will be used when available.

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	MCWP agency with Exemption Approved by CDPH/OA
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing, Registered Nurse

Provider Category:

Agency

Provider Type:

MCWP agency with Exemption Approved by CDPH/OA

Provider Qualifications

License *(specify):*

Business and Professions Code Sections 144, 480-487, 492, 493, 496, 810, 820-828, 2866, and 2872.1.

Certificate *(specify):*

Other Standard *(specify):*

CDPH/OA approved exemption

Verification of Provider Qualifications

Entity Responsible for Verification:

MCWP agency Project Director and CDPH/OA as appropriate

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing, Registered Nurse

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725

Certificate *(specify):*

N/A

Other Standard *(specify):*

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification and the MCWP agency Project Director.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

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:

Attendant Care

HCBS Taxonomy:

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

Service Definition *(Scope):*

Attendant care services provide a higher level of care for persons with HIV/AIDS who have needs that change on a routine basis and are different in nature from State Plan services. They must be provided by a Certified Home Health Aide (CHHA), Certified Nursing Assistant (CNA), or a person with CDPH Licensing and Certification Division's written approval of training equivalent to a CNA. Allowable attendant care services differ based on a provider's qualifications.
CHHA:
Through a licensed home health agency or hospice program, and under the instruction and supervision of a registered nurse, CHHAs provide basic nursing services, food preparation, and household services for individuals receiving Primary Care Provider-prescribed care. A CHHA may not provide any services that require a professional nursing or medical license. The CHHA communicates with the individual, observes responses to treatment and/or environment, and reports responses to a licensed nurse or therapist; provides and records personal care and comfort measures; and performs the following procedures:

- Prepares meals and assists individuals with eating;
- Assists with use of bedpan, urinal, and commode;
- Takes vital signs: temperature, pulse, respirations, and blood pressure;
- Measures height and weight; and
- Performs other activities taught by a health professional for a specific participant (i.e. changing colostomy bags or non-sterile dressings).

CNA:
Under the supervision of a licensed nurse (registered or vocational), the CNA provides basic nursing services to help ensure the safety, comfort, personal hygiene, and protection of individuals. CNAs may not perform any nursing services that require a professional nursing license. The CNA communicates with the individual, observes responses to treatment and/or environment, and reports responses to a licensed nurse; provides personal care and comfort measures; and performs the following procedures:

- Feeds individuals;
- Takes vital signs (temperature, pulse, respirations, and blood pressure);
- Measures height and weight;
- Assists with use of bedpan, urinal, and commode; and
- Assists with bowel and bladder retraining.

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

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

MCWP agencies' case management services are reimbursed a monthly flat fee per participant for enrolled participants.

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	Home Health Agency
Agency	Private Nonprofit or Proprietary Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725

Certificate *(specify):*

N/A

Other Standard *(specify):*

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757. Psychology, Counseling, Rehabilitation, or Sociology and at least one-year experience in case management.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification and the MCWP agency project director.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency

Provider Qualifications

License *(specify):*

Local California business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.
Must provide basic training on HIV/AIDS, infection control, and confidentiality.
The MCWP agency provides this service directly when an exemption has been approved by CDPH/OA.

Verification of Provider Qualifications

Entity Responsible for Verification:

MCWP agency Project Director and CDPH/OA as appropriate

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

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:

Home-Delivered Meals / Nutritional Supplements

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:**

Home-delivered meals and nutritional supplements are provided to meet the nutritional needs of MCWP participants who are unable to prepare their own meals and do not have a caretaker at home to prepare meals for them. Home-delivered meals and nutritional supplements may be provided daily but are not intended to meet all the nutritional needs of the participant (i.e., three meals a day). The number and frequency of meals and supplements per day will depend on the requirements in the PCSP.

Recognizing that good nutrition plays an integral role in optimizing the immune system, the use of food vouchers is permissible in lieu of or in addition to home-delivered meals or supplements. MCWP is not to be billed for participants receiving donated food or food fully paid for by another funding source.

An individual may provide home-delivered meals when a “meals-on-wheels” vendor is not available. In these cases, the following documentation must be included in the participant’s progress notes:
• There is no “meals-on-wheels” or similar vendor available.
• The amount being reimbursed for food and preparation cost is based on “usual and customary” fees charged by similar vendors.
• The written agreement which outlines the details between the agency and the individual providing the service.
Nutritional supplements are pre-packaged nutritionally fortified drinks (liquid or powder), health food bars, herbal therapy, vitamins, and other food items that will contribute to the nutritional or caloric intake of the participant. Bottled water is not considered to be a nutritional supplement and cannot be billed to the MCWP.

Nutritional supplements may be considered for participants including the following conditions:
• Medications and the disease process producing symptoms such as pain, nausea, loss of appetite, bloating or gas, vomiting and diarrhea that become barriers to the participant maintaining a healthful nutritional status
• Weight loss and muscle wasting
• Infections affecting the gastrointestinal system that prevent adequate absorption of food and make nutritional supplements necessary.

Any medically necessary nutritional supplements for participants under age 21 must be first billed to Early and Periodic Screening, Diagnostic and Treatment.

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

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

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	Private Nonprofit or Proprietary Agency or Business
Agency	Local pharmacy or vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals / Nutritional Supplements

Provider Category:
Agency
Provider Type:

Private Nonprofit or Proprietary Agency or Business

Provider Qualifications
License *(specify):*

Local business license, and any others as required by local governments.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The MCWP agency provides this service directly when an exemption has been approved by CDPH/OA.

Verification of Provider Qualifications
Entity Responsible for Verification:

MCWP agency Project Director and CDPH/OA as appropriate.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals / Nutritional Supplements

Provider Category:
Agency
Provider Type:

Local pharmacy or vendor

Provider Qualifications
License *(specify):*

Local business license, and any others as required by local governments.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

MCWP agency Project Director and CDPH/OA as appropriate.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

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:

Medi-Cal Supplements for Infants and Children in Foster Care

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 Medi-Cal supplements for infants and children in foster care service is intended to facilitate placement efforts and compensate foster parents for increased costs and services when foster care funds, including the Specialized Care Rates program and the Substance Abuse/HIV Infant Program, or other services and supports, are unavailable or insufficient for eligible clients under 18 years of age.

The need for this supplement must be documented in the client's progress notes. Foster Families are screened and trained by the CA Department of Social Services and licensed through Department of Public Health Community Care Licensing. The AIDS Waiver Agency case manager is responsible for obtaining documentation of substantiating licensure. AIDS Waiver does not require additional documentation of training, experience, or education. The cost of room and board is not included in this supplement.

Waiver agencies must access all other resources, including county funds (for example, foster family home basic rates and specialized care rate incentives and assistance programs), prior to billing the Waiver for these services. The Waiver is the payer of last resort after all other sources of funding, including federal, State, local and private entities.

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

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

This service has a monthly cap of $338 per client.

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	Foster Parent

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medi-Cal Supplements for Infants and Children in Foster Care

Provider Category:

Individual

Provider Type:

Foster Parent

Provider Qualifications

License *(specify):*

CCR, Title 22, Division 6, Chapter 9.5

Certificate *(specify):*

Other Standard *(specify):*

Foster Families are screened and trained by the CA Department of Social Services and licensed through Department of Public Health Community Care Licensing. The Waiver Agency case manager is responsible for obtaining documentation of substantiating licensure. AIDS Waiver does not require additional documentation of training, experience, or education.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social Services and individual Counties

Frequency of Verification:

At application, annual training, and/or complaint investigation

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:

Minor Physical Adaptations to the Home

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:**

Minor physical adaptations to the home consist of physical adaptations to the home which are required by the participant's PCSP and are necessary to help ensure the health, welfare and safety of the individual, or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are essential for the health and welfare of the participant. Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant are excluded. Adaptations that add to the total square footage of the home are excluded, except when necessary to complete an adaptation.

If the provision of a service requires obtaining a local building permit(s), the service provider must be licensed. For jobs smaller in scope, MCWP agency staff checks references to confirm the legitimacy of the service provider and documents this information and the type of services provided in the PCSP.

If a MCWP participant does not own the home where they reside, written permission must be obtained from the landlord and noted in the plan of care before making adaptations.

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

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

Minor physical adaptations to the home are not to exceed $1,000 per client per calendar year.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Nonprofit or Proprietary Agency or Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Physical Adaptations to the Home

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency or Business

Provider Qualifications

License *(specify):*

Local business license, and any others as required by local governments. If the service requires local building permits, then the service provider must be licensed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

For jobs of smaller scope, the MCWP agency staff checks references to confirm the legitimacy of the service provider. Reference check information and the type of services provided should be documented in the individual's PCSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

MCWP agency Project Director

Frequency of Verification:

Prior to/at time of employment.

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:

Non-Medical Transportation

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:

Non-Medical Transportation (NMT) consists of those services which enable MCWP participants to gain access to MCWP and other community services, activities, and resources. Whenever possible, family, neighbors, friends, or community agencies are utilized. This includes non-medical transportation to health and social service providers stipulated in the PCSP when the participant does not have the means for transportation. Waiver participants are able to travel by bus, passenger car, taxicab, or another form of public or private transportation and do not require an ambulance, wheelchair van, or litter van. MCWP participants under age 21 must receive the service via the state plan pursuant to Early and Periodic Screening, Diagnostic, and Treatment prior to utilizing transportation under the MCWP. Privately owned vehicles may be used when the qualified case manager determines the participant is capable of travel by private vehicle and when a commercial vehicle is not available or is more expensive. Use of taxi/shuttle vouchers and reimbursement of gas and automobile usage (at current State rates) is also permissible. Beneficiaries will need to attest to the provider verbally or in writing that they have an unmet transportation need and all other currently available resources have been reasonably exhausted. Reasons for needing NMT can include any of the following:

- No valid driver's license.
- No working vehicle available in the household.
- Not being able to travel or wait for covered Medi-Cal services alone.
- Having a physical, cognitive, mental, or developmental limitation.
- No money for gas to get to appointment.

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

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

This service is subject to a $40 monthly cap per client.

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	Private Nonprofit or Proprietary Agency or Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency or Business

Provider Qualifications

License *(specify):*

Local business license, and any others as required by local governments.

Certificate *(specify):*

Other Standard *(specify):*

CDPH/OA may provide an exemption to a MCWP agency if an individual cannot be contracted for this service and the MCWP agency has a qualified individual who can provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

MCWP agency Project Director

Frequency of Verification:

Prior to/at time of employment

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:

Nutritional Counseling

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:**

This service provides participants and their caregivers with guidance on the promotion of eating habits and food choices that maximize nutritional opportunities for the participant who is faced with disease symptoms such as nausea or diarrhea, and prevent potential drug/food interactions, and teaches the importance of using nutrition to optimize the immune system. Food choices can be planned to meet ethnic and personal choices and financial constraints. Nutritional counseling services are provided by a Registered Dietitian who has agreed with the MCWP agency to work on a consultant basis. Nutritional counseling for participants under age 21 must be first billed to Early Periodic Screening, Diagnostic, and Treatment Services. For participants 21 years and over, documentation must show that Medical Nutrition Therapy offered by State Plan and extended State Plan has been exhausted. The services under the MCWP are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

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

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

Services will be paid for based on an hourly rate and the frequency and need for services will be determined by the qualified case manager.

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	Private Nonprofit or Proprietary Agency or Business
Individual	Registered Dietitian

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency or Business

Provider Qualifications

License *(specify):*

Local business license, and any others as required by local governments.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The MCWP agency provides this service directly when an exemption has been approved by CDPH/OA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Project Director at the MCWP agency and CDPH/OA as appropriate.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

Provider Category:

Individual

Provider Type:

Registered Dietitian

Provider Qualifications

License *(specify):*

California Code of Regulations (CCR), Business and Professions Code, Division 2, Chapter 5.65 Section 2585-2586.8

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

MCWP agency Project Director

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

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:

Psychotherapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Psychotherapy is provided to MCWP participants with regard to the psychological adjustment to living with HIV/AIDS. The Psychotherapist may also provide therapy to caregivers of MCWP participants with end-stage AIDS. This service may be provided with or without the participant present. Providing this service will help prevent caregiver burnout, decrease ineffectiveness, improve caregiver performance, and assist caregivers in coping with the MCWP participants impending death. Individuals providing psychotherapy services may not also be the participant's case manager or perform administrative activities. The services under the MCWP are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

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

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

Services will be paid for based on a maximum hourly rate. The frequency and need for services will be determined at the interdisciplinary team case conference (IDTCC).

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	Masters Degree Nurse: Psychiatric & Mental Health Clinical Nurse Specialist or Psychiatric & Mental Health Nurse Practitioner
Individual	Clinical Psychologist
Individual	Licensed Clinical Social Worker (LCSW)
Individual	Marriage and Family Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychotherapy

Provider Category:
Individual
Provider Type:

Masters Degree Nurse: Psychiatric & Mental Health Clinical Nurse Specialist or Psychiatric & Mental Health Nurse Practitioner

Provider Qualifications

License *(specify):*

California Code of Regulations (CCR), Title 16, Section 1409, Nursing Practice Act, Division 2, Chapter 6, Article 1, Section 2732

Certificate *(specify):*

Other Standard *(specify):*

Accredited School of Counseling.

CDPH/OA may provide an exemption to a MCWP agency if an individual cannot be contracted for this service and the MCWP agency has a qualified individual who can provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Project Director at the MCWP agency

Frequency of Verification:

Prior to/at time of employment and Every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychotherapy

Provider Category:
Individual
Provider Type:

Clinical Psychologist

Provider Qualifications

License *(specify):*

CCR, Title 16, Division 13.1 and BPC, Chapter 6.6, Section 2903

Certificate *(specify):*

Other Standard *(specify):*

Master's degree from an Accredited School of Psychology

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Consumer Affairs, Board of Psychology; Project Director at the MCWP agency

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychotherapy

Provider Category:
Individual

Provider Type:

Licensed Clinical Social Worker (LCSW)

Provider Qualifications

License *(specify):*

CCR, Title 16, Division 18 and Business and Professions Code (BPC) Division 2, Chapter 14, Articles 1-4, Sections 4990-4998.7

Certificate *(specify):*

Other Standard *(specify):*

CDPH/OA may provide an exemption to a MCWP agency if an individual cannot be contracted for this service and the MCWP agency has a qualified individual who can provide the service..

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Consumer Affairs, Board of Behavioral Sciences; Project Director at the MCWP agency

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychotherapy

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

CCR Title 16, Division 18 and BPC Chapter 13, Article 1-7, Sections 4980-4989

Certificate *(specify):*

Other Standard *(specify):*

CDPH/OA may provide an exemption to an MCWP agency if an individual cannot be contracted for this service and the MCWP agency has a qualified individual who can provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Consumer Affairs, Board of Behavioral Sciences; Project Director at the MCWP agency

Frequency of Verification:

Every two years

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:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Service Definition *(Scope):*

The specialized medical equipment and supplies service provides devices, controls, or appliances, as specified in the plan of care, which enable participants to increase their ability to perform daily living activities, or to perceive, control, or communicate with the environment in which they live.

This service also includes the provision of items which are necessary for life support, including all ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment. Items that are not of direct medical or remedial benefit to the individual shall be excluded. All items shall meet applicable standards of manufacture, design, and installation.

This service is necessary to provide an alternative to institutionalization and must be immediately needed for the participant's care and safety. The MCWP agency must document and justify need for the item(s) in the client's service record. Purchase authorization shall be granted only when the MCWP agency has indicated and documented that good faith effort to provide specialized medical equipment and supplies through the State Plan have been denied. The services under the MCWP are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

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

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	Private Nonprofit or Proprietary Agency or Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency or Business

Provider Qualifications

License *(specify):*

Local business license, and any others as required by local governments. If the service requires local building permits, then the service provider must be licensed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Project Director at the MCWP agency

Frequency of Verification:

Prior to/at time of employment.

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):

Registered Nurse, Psychiatric/Mental Health Nurse Specialist, Licensed Vocational Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist, and Psychologist:
The Department of Consumer Affairs (DCA) conducts criminal history/background screening record clearance as a condition of initial certification and recertification. DCA denies, suspends, or revokes the application or recertification of individuals who do not pass criminal history/background screenings. DCA uses live scan technology to electronically transmit fingerprints directly to the Department of Justice (DOJ). DOJ checks the fingerprints against their records and sends file information to the Federal Bureau of Investigation for review. Citations: Business and Professions Code Sections, 144, 480-487, 492, 493, 496, 810, 820-828, 2750-2765, 2795-2796, 2866, 2872.1, 2914-2915, 4980-4989, 4990-4998, and Penal Code Section 11105, subd. (b)(10).

Certified Home Health Aide and Certified Nurse Assistant:
CDPH Licensing & Certification conducts criminal history screening clearances as a condition of initial certification and recertification. CDPH Licensing & Certification denies, suspends, or revokes the application or certificate of individuals who do not pass criminal history/ background screenings. CDPH Licensing & Certification electronically transmits fingerprints directly to DOJ using live scan technology. Home Health Agencies must consult the abuse registry prior to hiring direct care staff and implement a system to confirm only currently licensed individuals are employed. Citations: Health and Safety Code Sections 1728.1, 1728.2, 1736.4, 1736.5(a), 1736.6.

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):

Registered Nurse, Psychiatric/Mental Health Nurse Specialist, Licensed Vocational Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist, and Psychologists: DCA conducts abuse screening record clearance as a condition of initial certification and recertification. DCA denies, suspends, or revokes the application or recertification of individuals convicted. Citations: Business and Professions Code Sections, 144, 48-487, 492, 493, 496, 810, 820-828, 2750-2765, 2795-2796, 2866, 2872.1, 2914-2915, 4980-4989, 4990-4998, and Penal Code Section 11105, subdivision B.

Certified Home Health Aide and Certified Nurse Assistant:
CDPH Licensing & Certification conducts background checks and abuse screening clearances as a condition of initial certification and semi-annual recertification. CDPH Licensing & Certification denies, suspends, or revokes the application or certificate of individuals convicted. Citations: Health and Safety Code 1736.1, 1736.2, 1736.7.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

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:

There is no specified open enrollment timeframe for potential MCWP agencies to enroll as providers in the MCWP. All qualified providers interested in enrolling may do so at any time during the term of the approved waiver. Information on the MCWP is available on the Office of AIDS website:
https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_mcwp.aspx

Interested providers are encouraged to contact CDPH/OA staff for more information. Providers that choose to enroll in the program are assessed for pertinent qualifications which meet MCWP service delivery standards and are then required to enter into a contract with CDPH/OA upon approval.

MCWP agencies are also required to recruit service providers on an ongoing basis and at least annually. MCWP agencies typically recruit service providers by asking community vendors if they would be interested in providing their services to MCWP participants. CDPH/OA staff reviews and discusses provider recruitment efforts with Project Directors during their 24-month program compliance reviews.

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:
#/% of MCWP agencies who certify at the initial time of hire and/or subsequent renewal and report bi-annually to CDPH/OA that all case managers (Registered Nurse and Social Worker) meet the minimum qualifications Numerator: Number of MCWP agencies who certify and report bi-annually that all case managers meet the minimum qualifications/Denominator: Total number of contracted MCWP agencies

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bi-annual Progress Report reviews and Record reviews, on-site and/or electronic

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

	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
#/% of MCWP agency subcontractor files containing documentation of adherence to required licensure/certification prior to the provision of MCWP services Numerator: Number of MCWP agency subcontractor files containing documentation of adherence to required licensure/certification prior to the provision of MCWP services/Denominator: Total number of MCWP agency subcontractor files reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bi-annual Progress Report reviews and Record reviews, on-site and/or electronic

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

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

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:
#% of MCWP agencies verify that all case management staff completed required annual training Numerator: MCWP agencies that certify staff completed annual training/Denominator: Total number of MCWP agencies

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bi-annual Progress Report reviews and Record reviews, on-site and/or electronic

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: Biannually	

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: Biannually

Performance Measure:

#% of MCWP agencies who verify that subcontractors providing skilled nursing, homemaker, or attendant care completed required annual training Numerator: MCWP agency subcontractors that completed required annual training/Denominator: Total number of MCWP agency subcontractors

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bi-annual Progress Report reviews and Record reviews, on-site and/or electronic

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: Biannually	

Data Aggregation and Analysis:

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

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

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.

N/A

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.

CDPH/OA works collaboratively with the MCWP agency's Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the MCWP agency during the exit conference, and a formal written SOF is provided to the MCWP agency following the review. The MCWP agency is required to submit a CAP, which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to confirm the MCWP agency appropriately addresses the findings.

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**

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

1. Home/minor physical adaptations are limited to $1,000 per MCWP participant per calendar year. Physical adaptations are a "by request" item in the State plan. Except in unusual circumstances, the $1,000 limit covers items/costs not covered by the State plan. The limit for this service is based on historical costs and utilization. MCWP agencies have other resources to help meet this need, should it occur. The limits set for these services are equivalent to like services and are based on usual and customary costs of services, which are equivalent for non-Medi-Cal clients. MCWP agencies solicit three bids for services and take the best value at lowest cost.

2. The limit for spending on nutritional supplements is $150 per participant per month. This limit is based on historical costs and utilization. The $150 limit has historically met participants' needs. Nutritional supplements are not covered in the State Plan. This limit is based on historical utilization/cost patterns. The calendar year costs limit for participants is lower than the average per capita for institutional participants.

A case manager discusses these limits with each participant at the time of enrollment and when these services are authorized in the PCSP. Service costs are monitored through the year by the case manager. If it appears that the limit will be reached prior to the end of the year, the case manager and participant will discuss reducing necessary services to avoid exceeding the cap. If the amount of the limit is reached, the participant is disenrolled from MCWP and enrolled in the Federal Ryan White HIV/AIDS Program (if available and appropriate), which is the payer of last resort. If other services are not available when the limit is reached, the participant has the potential to be institutionalized until the start of the next fiscal year.

CDPH/OA and DHCS/HCDS/ISCD may conduct studies to determine if the amount of the aforementioned limits needs to be adjusted. The last analysis the State conducted was in the fourth quarter of 2016. The methods employed to make such determinations shall be objective, evidence-based, and applied consistently statewide. If a limit must be adjusted during the Waiver term, the State would submit a Waiver Amendment to CMS. The amount of a limit would be adjusted by submitting an Operating Instruction Letter (OIL) to the FI to increase or decrease a limit.

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:

Comprehensive Service Plan (CSP)

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 state has established the following safeguards to help ensure that service plan development is conducted in the best interests of the participant:
When a MCWP agency is the only willing and qualified entity to provide direct care services in a geographic area, they may apply for an exemption to the conflict of interest standard. A MCWP agency must submit a written exemption request form outlining the services they wish to provide, who will provide these services, and the reason(s) services could not be secured by subcontract. CDPH/OA staff grants exemptions on a case by case basis and services may not be provided prior to exemption approval. Exemptions are only approved in cases where there is clear evidence that the MCWP agency has made a good faith effort to secure direct care services subcontractors. Exemptions are granted for no more than one year at a time and are rescinded if the MCWP agency is unable to maintain compliance with MCWP policies and procedures. When a MCWP agency is granted exemption, the direct care service may not be delivered by core MCWP agency staff (i.e., Project Director, Nurse Case Manager, Social Work Case Manager). The MCWP agency Nurse Case Manager and Social Work Case Manager are responsible, in partnership with the participants, in assessment and service planning, therefore, they are limited to the case management provision and may not deliver direct care services. The Project Director is also prohibited from providing direct cares services.

In order to help ensure that care planning and services are provided in the best interest of the participant, a MCWP agency that wishes to provide case management and other services must demonstrate that the participants' are informed of all alternative available resources in their area, utilize the standard level of care assessment for all participants, incorporate participant's preferences in the development of the individualized care plan, inform participants of their right to a grievance procedure, and conduct an annual participant satisfaction survey. Results of the participant satisfaction surveys are summarized and submitted to CDPH/OA staff annually.

Monitoring for compliance and conflict of interest is conducted by CDPH/OA staff during PCRs, bi-annual progress reports and participant satisfaction surveys reviews, and claims data as needed.

The state restricts the entity that develops the person- centered service plan from providing services without the direct approval of the state.

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.

When an individual is determined to be eligible for MCWP, the individual is provided a description of MCWP services, limitations, and requirements, and any feasible alternative programs. The individual is then given the choice between the MCWP and other care and/or institutionalization options and then between MCWP services and providers. The participant acknowledges that they were given the above choices by signing the Informed Consent/Agreement to Participate form. The participant is required to be involved in the service plan process and indicate their agreement with all services by signing the PCSP. The participant has the authority to include individuals of their choice to participate in the service plan development process.

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):

A) Who Develops, Who Participates In, and Timing of the PCSP:
MCWP agency's nurse case manager, social work case manager, and participant collaborate to develop a PCSP which addresses the participant's needs, goals, and preferences. The PCSP must be initiated at the time of enrollment and prior to delivery of MCWP services. The PCSP is reviewed at least every 365 days and updated on an ongoing basis if participant's needs are assessed to change.

The interdisciplinary team consists of the participant and/or their legal representative, primary care provider, and the parent or guardian if the participant is a child. The team solicits the participant's input when developing the PCSP.

The PCSP identifies the participant's service needs (as documented in the face-to-face comprehensive participant assessment/reassessments and progress notes as appropriate), and the services to be provided to that participant (including informal supports that complement MCWP services). All services that a participant will receive must be identified in the PCSP, regardless of funding source. MCWP services must be specified by type, amount, duration, scope, and frequency before provision of services.

B) Types of Assessments Conducted to Support the PCSP:
Nursing Assessment:
Conducted by the qualified nurse case manager on or within 15 days prior to enrollment and reassessments at least every 365 days thereafter. The comprehensive medical review includes screening and/or assessing the following:
- Vital signs;
- Physical exam;
- Comprehensive systems review;
- Pertinent physiological information;
- Level of orientation;
- Cultural information;
- Current health status and habits;
- Need for and availability of caregivers;
- Transmission prevention (safe/safer sex, needle sharing, harm reduction techniques);
- Medications and known or increasing side effects;
- Complimentary or alternative therapies;
- Adherence to medication regimen;
- Barriers to adherence;
- Health history;
- Nutritional assessment;
- Risk assessment and mitigation;
- SOF and plan for next 180 days: and
- Certification of Nursing Facility Level of Care.

Psychosocial Assessment:
Conducted by the qualified social work case manager on or within 15 days prior to enrollment and reassessments at least every 365 days. The review includes an assessment of the following:
- Family and support systems;
- Coping strategies;
- Strengths and weaknesses;
- Adjustment to illness;
- Education;
- Cultural factors;
- Legal issues (legal history, wills, Durable Power of Attorney and/or Durable Power of Attorney for Healthcare);
- Funeral arrangements;
- Substance use/abuse history and current risk behaviors;
- Resources and needs in regard to food, housing, and transportation;
- Finances;
- Transmission prevention (safe/safer sex, needle sharing, harm reduction techniques);
- Risk assessment and mitigation; and
- SOF and plan for the qualified case manager for the next 365 days.

Resource Evaluation:

Conducted by the qualified case manager on or within 15 days prior to enrollment and reassessments at least every 365 days. This is a screening of benefits and/or entitlements a participant may be receiving or is potentially eligible for. The following is assessed:
- Private medical insurance;
- Medicare;
- Medi-Cal managed care;
- Medi-Cal;
- AIDS Drug Assistance Program (ADAP);
- California Children's Services (for children only); and
- In-Home Supportive Services (IHSS).

Home Environment Assessment:
Conducted by the qualified case manager within 30 days of enrollment with reassessments conducted at least once a year and when the participant moves. The review includes an assessment of the following:
- Structural integrity;
- Availability of adequate heating and cooling system;
- Electricity;
- Gas;
- Hot and cold running water;
- Food storage and preparation facilities;
- Basic furnishings;
- Cleanliness;
- Presence of hazards;
- Functional plumbing;
- Telephone services;
- Laundry facilities; and
- Care of pets (if any).

C) How the participant is informed of the services that are available under the MCWP:
When an individual is interested in participating in the MCWP, a qualified case manager describes the services, limitations and requirements of the MCWP and any feasible alternative programs to him/her. The qualified case manager answers any program questions the individual has, as well as provides the interested party with documentation further outlining the participation requirements as outlined in the Informed Consent/Agreement to Participant forms. All applicant questions are to be resolved by the qualified case manager prior to enrollment and development of the PCSP.

D, E, & F) PCSP Process:

Participant Goals, Needs, Preferences; Service Coordination; Implementation; and Monitoring.
Qualified case managers utilize the baseline information from the comprehensive participant assessments to develop the initial PCSP. The PCSP includes, but is not limited to, the following elements:
- Long-Term Goals: One or more brief statements expressing the primary reason(s) for the participant's enrollment in the program and the purpose for the provision of case management services.
- Identified Problems or Needs: A brief statement of the problem or need identified by the participant and case manager during the assessment, reassessment, or through other contact with the participant and interdisciplinary team. Documentation of the assessments must support or describe the identified problem or need in more specific detail.
- Stated Goals/Objectives: The stated goals and objectives must include the desired outcome. The outcome should address the resolution or management of the identified problem or need.
- Services and Interventions: A brief description of the services the participant is receiving, or will receive, which addresses the identified problem or need, and whose aim is to meet the stated goals and objectives. This includes: the service/type of provider, frequency, quantity, and duration of the service (e.g., attendant care, XYZ Home Health Agency, four hours per day, twice weekly, for two months).
- Payment source for the stated services and interventions.
- Initials and signature of the qualified case manager developing the PSCP and each update.
- Participant signature and date signed on initial PSCP and each update.
- Date problem or need was identified and the start date for services/interventions.
- Documentation that the Primary Care Provider has been notified of the contents of the initial PCSP.
- Documentation that the participant or their legal representative has had input regarding the contents of the initial PCSP

and updates, including needs, goals, and preferences.

Cost Avoidance:
• All other available resources are screened for and accessed prior to utilization of MCWP funds when arranging participant’s services/interventions.
• MCWP agency staff document cost avoidance activities in the participant’s record each time they occur.
• Documentation covers what agencies/resources were accessed, what services were requested, and why services could not be provided.

G) PCSP Reviews, Updates, and Revisions:
• The PCSP is reviewed, updated, and revised as problems and/or service needs change.
• Any updates or revisions to the PCSP shall include the same required elements which applied to the original PCSP.
• At least every 365 days, or as warranted by changes in participant’s condition the case managers review all components of the PCSP including input from participant and/or legal representative.

The PCSP is kept current by the MCWP case managers through ongoing monitoring with at least monthly telephone contact and quarterly face to face visits to assure that the services are meeting the MCWP participant's needs. Per the participant’s choice, “face-to-face” visits referenced can be through synchronous telehealth (includes a real-time live interaction) or in-person.

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.

MCWP qualified case managers conduct face-to-face comprehensive assessments and reassessments of all participants. Potential risks to the participants are assessed during face to face assessments, monthly face-to-face or telephonic monitoring contacts, and as needed. Risk areas assessed include home environment, health, falls, nutrition, self-care, financial, medications, cognition, emotional, activities of daily living, abuse, neglect, exploitation, personal safety, resources, mental health, wellness, and behavior. Qualified case managers use this information and obtain participant and/or family/representative input when developing the PCSP.

Qualified case managers work to connect participants with appropriate services and supports. The PCSP indicates who is responsible for providing each service. The case managers monitor the PCSP services furnished by providers outside of the MCWP agency providers. The PCSP is reviewed with the participant at least every 365 days during reassessments or as warranted by changes in participant’s condition. Strategies to mitigate participant risk, including supports other than MCWP services, are incorporated in the PCSP and are tailored to each participant’s needs and preferences. Ongoing risk assessment and mitigation is monitored during regular monthly contacts by the case manager.

Each MCWP agency shall develop and implement policies and procedures to promote continuity in the provision of enhanced case management services during expected and unexpected absences of case management staff. MCWP agencies shall review their policies and procedures annually and revise as necessary. CDPH/OA shall review these policies and procedures every 24 months during MCWP Program Compliance Reviews.

Each MCWP agency and the agencies with whom they subcontract develop and maintain backup PCSPs for the provision of services during the absence of direct care service providers. CDPH/OA monitors MCWP agencies’ compliance regarding backup PCSPs.

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.

To permit that participants have choice of providers, MCWP agencies are required to offer, when possible, at least three providers from each service category. During PCSP development, case managers provide participants with information on available providers, and discuss participants' preferences and choice of service providers. The MCWP participants acknowledge that they were given the above choices by signing the PCSP. Participants are continuously provided options of qualified providers and available service providers. On an ongoing basis, MCWP participants are encouraged to identify providers of waiver services who can best meet their 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 case management team, 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 case management team can assist the participant and/or legal representative/legally responsible adults in identifying and accessing qualified waiver service providers.

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):

MCWP agencies use the PCSP form and PCSP Attachment A. CDPH/OA staff review and discuss the requirements with the Project Director during the 24-month Program Compliance Review and provides feedback and/or technical assistance as necessary. DHCS/HCDS/ISCD shall work collaboratively with and/or independently of CDPH/OA to ensure compliance with state and federal regulations, Medicaid statutes, the interagency agreement between DHCS and CDPH, and MCWP requirements ensure the PCSP is approved in accordance with 42 CFR §441.301 (b)(1)(i).

The state monitors PCSP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of PCSPs. If errors in PCSPs are identified, the written report of the findings and recommendations that is issued to the site from CDPH/OA will include a formal written request for a CAP specific to remediating the errors. The site is required to respond to CDPH/OA and develop a formal plan to cover any deficiencies identified, which is then monitored by CDPH/OA.

DHCS/HCDS/ISCDs' review of CDPH/OA SOF reports and CAPs occurs on an ongoing basis. Additionally, the DHCS/HCDS/ISCD compliance team may accompany the CDPH/OA team during Program Compliance Reviews, as needed, to ensure all programmatic and Waiver requirements are being met. DHCS/HCDS/ISCD maintains authority to conduct independent on-site and or electronic visits to address deficiencies and to train/educate the MCWP agencies as appropriate. DHCS/HCDS/ISCD and CDPH/OA hold regular calls to discuss Program Compliance Reviews, including any PCSP related findings.

A CDPH/OA team, consisting of a Registered Nurse and Program Advisor, conducts a comprehensive Program Compliance Review (PCR) of each MCWP agency at least once every 24 months. The PCR consists of a contract monitoring component and participant record review component.
The participant record review component reviews and evaluates:

- MCWP eligibility including appropriate level of care assessments;
- Consent forms;
- Necessity and appropriateness of services;
- Timeliness and appropriateness of assessments, reassessments, PCSPs;
- Appropriate notice of action when applicable;
- Appropriate follow-up on participant grievances; and
- Appropriateness of payment for services delivered.

DHCS reviews the PCRs, site Corrective Action Plans and data reports, to ensure compliance with state and federal regulations, Medicaid statutes, the interagency agreement between CDPH and DHCS, and waiver requirements, on an ongoing flow basis. If DHCS' review identifies continued programmatic noncompliance, DHCS may recommend sanctions until the concerns are rectified. Depending on the findings, the sanctions can range from financial sanctions to discontinuation of the MCWP agency's contract to provide Waiver services.

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:

365 days or more frequently when necessary or upon participant's change of condition or service need

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:

As part of their agreement with CDPH/OA, MCWP agencies must maintain each participant’s service record, including electronic or hard copies of PCSPs, during enrollment in the MCWP and for a minimum of three years after the participant's case is closed. MCWP agencies must be Health Insurance Portability & Accountability Act (HIPAA) compliant and follow guidelines as outlined in the agency contract, for record handling and documentation practices for health care records.

MCWP agencies must keep active participant records onsite in locked storage areas (protected from potential damage and/or unauthorized access) which are accessible only by MCWP agency staff directly responsible for filing, charting, and review, and to State and federal representatives as required by law. No documents shall be destroyed or removed from a record once entered. Each MCWP agency shall establish a plan for the storage and retrieval of records in the event of closure. All MCWP agencies policies must address how records are to be stored, removed and destroyed no earlier than ten years following the final payment of the agreement, be HIPAA compliant, and follow guidelines as outlined in the agency contract, for record handling and documentation for health care records.

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.

PCSP Implementation and monitoring are performed by the MCWP agency. Service needs are identified, and services are arranged for during the PCSP planning process. The PCSP is kept current by the participant's case manager through ongoing monitoring with at least monthly telephone contact and quarterly face-to-face visits to assure that the services are meeting the participant's needs. Review, discussion and updating of the PCSP and associated services are core components of these contacts. Monthly contacts and quarterly face-to-face visits are documented in the progress notes in the MCWP participant's record. During the monthly contacts and quarterly face-to-face visits, the case manager will work with the participant to determine if they are satisfied with current services and service providers.

Changes to the PCSP can occur anytime based on changes in the MCWP participant's situation in ongoing efforts to best meet the participants' needs during the course of the PCSP. In addition, an interdisciplinary team case conference (IDTCC) is held for each participant at least quarterly to align with the quarterly face-to-face visits. The team consists of the participant and/or their legal representative, the qualified case managers, and the parent or guardian (if the participant is a child), the Project Director, and other service providers involved. The primary care provider(s) may also participate.

If service providers are unable to attend, information regarding the participant's status and continued need for services shall be collected by the nurse case manager and/or social work case manager prior to the case conference who will present the information at the IDTCC, as appropriate.

If the participant or their legal representative is unable to attend, the participant or their legal representative input is gathered during reassessments and other contacts with the qualified case manager.

During the IDTCC, qualified case managers address the medical, psychosocial, housing, and financial needs of each participant and how their PCSP seeks to address these needs in the coming months. The qualified case manager review the PCSP, evaluate the services the participant is receiving, review the participant's current status, discuss any changes in the participant's status and the length of time the participant is anticipated to be on the MCWP with the participant. The qualified case manager documents the following information in each participant's record: the names, licenses and/or degrees and titles of those attending the conference, relevant information discussed, and whether the participant or their legal representative had input in the conference.

Each MCWP agency must have policies and procedures for protecting participant confidentiality during the IDTCCs.

The agency is required to subcontract with a sufficient number of service providers to allow the participant or legal representative to choose from at least three providers for each service when possible, based on the availability of participating service providers in each geographic area.

If the MCWP agency is unable to secure a subcontractor, they may file a request for a Direct Care Services (DCS) exemption from CDPH/OA staff for the following reasons: there are no subcontractors in the area, lack of subcontractors willing to accept Medi-Cal reimbursement rates, and/or the inability of subcontractors who can provide culturally and linguistically appropriate services. If the MCWP agency is unable to provide the services directly through the DCS exemption, then the agency will attempt to find services for participants through other programs such as the Federal Ryan White Program.

Case managers work with participants to determine appropriate services in the PCSP, which includes non-MCWP services. All potential funding sources must be exhausted prior to utilizing MCWP funds, including but not limited to private insurance, state plan services, and managed care plan services. The case managers or other agency staff must document these instances of cost avoidance in the PCSP each time they occur. Case Managers are required to monitor participant health and safety including effectiveness of back-up plans and service plan delivery each month. Documentation includes: the date of each attempt to contact the participant, any changes in participant need, changes in the service plan, verification that participant is receiving services in the type, scope, frequency, duration, and quantity described in the Participant Centered Service Plan and progress towards service plan goals. During Program Compliance Reviews, CDPH/OA staff review monthly progress notes to ensure all elements are addressed.

If unable to remediate identified problems using state plan services and MCWP services, an agency may request an Exemption to Provide Direct Care Services to provide the service using direct care agency staff. If unable to provide direct care agency staff, the participant may be disenrolled from the MCWP and enrolled in the federal Ryan White program or is at risk for institutionalization if the unmet need is significant.

The formal chart review SOF Report is provided from CDPH/OA to the agency and DHCS/HCDS/ISCD within 30 days of each biennial PCR. Agencies are required to provide CAPs for all findings listed in the SOF and submit to CDPH/OA within 30 days of the receipt of the SOF report.

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:*

When a MCWP agency is the only willing and qualified entity to provide direct care services in a geographical area, they may apply for an exemption to the conflict of interest standard. A MCWP agency must submit a written exemption request form outlining the services they wish to provide, who will provide these services, and the reason(s) services could not be secured by subcontract. CDPH/OA staff grants exemption on a case by case basis and services may not be provided prior to exemption approval. Exemptions are only allowable in cases where there is clear evidence that the MCWP agency has done due diligence in attempting to secure subcontractors for direct care services. Exemptions are granted for no more than one year at a time and will be rescinded if the MCWP agency is unable to maintain compliance with MCWP policies and procedures. An agency may receive an exemption to provide a direct care service, however those services may not be delivered by core MCWP staff including the Project Director, Nurse Case Manager and Social Work Case Manager. The MCWP agency Nurse Case Manager and Social Work Case Manager are responsible, in partnership with the participants, in assessment and service planning, therefore they are limited to case management provision and may not deliver direct care services. The Project Director is also prohibited from providing direct cares services.

In order to encourage that care planning and services are provided in the best interest of the participant, a MCWP agency that wishes to provide case management and other services must demonstrate that the participants' are informed of all alternative available resources in their area, utilize the standard level of care assessment for all participants, incorporate participant's preferences in the development of the individualized care plan, inform participants of their right to a grievance procedure, and conduct an annual participant satisfaction survey. Results of the participant satisfaction surveys are summarized and submitted to CDPH/OA staff annually.

Monitoring for compliance and conflict of interest is conducted by CDPH/OA staff during PCRs, bi-annual progress reports and participant satisfaction surveys reviews, and claims data as needed.

Agencies are required to demonstrate a good faith effort for obtaining qualified providers by documenting outreach efforts, including methods of solicitation and reasons why providers declined the solicitation offers. During PCRs, an OA health program advisor reviews the outreach efforts made by a MCWP agency to determine if good faith efforts were met and that the exemption request is appropriate. In addition, during PCRs an OA Registered Nurse and Program Advisor reviews PCSP in the participant medical records to determine if the services listed in the PCSP are appropriate based on the medical needs of the participant. If the services rendered are irregular and/or above and beyond the level of care needed as documented in the PCSP then this constitutes a finding, and the agency is required to submit a CAP to remedy the finding. If the MCWP agency continues to be out of compliance after the CAP is submitted, then the matter is referred to DHCS Audits & Investigations for further review. If DHCS Audits & Investigations review identifies continued programmatic non-compliance, they may recommend sanctions until the concerns are rectified. Depending on the findings, the sanctions can range from financial sanctions to discontinuation of the MCWP agency's contract to provide Waiver services.

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:
#/% of Records reviewed that had a Participant Centered Service Plan which included participant input addressing all individualized goals Numerator: Number of Participant Centered Service Plans that documented participant input addressing all individual goals/Denominator: Total number of participant records reviewed

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

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: Biennially	

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: Biennially

Performance Measure:

#/% of Participant Centered Service Plans that address all MCWP participants' assessed needs including health and safety risk factors Numerator: Number of Participant Centered Service Plans that addressed all MCWP participants assessed needs including health and safety/Denominator: Total number of MCWP participant records reviewed

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

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: Biennially	

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):*
	Biennially

Performance Measure:
#/% of Participant Centered Service Plans reviewed that include progress monitoring of service plan goals Numerator: Number of Participant Centered Service Plans reviewed that include documentation of progress monitoring of service plan goals/Denominator: Total number of MCWP participant records reviewed

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

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: Biennially	

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: Biennially

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:
#/% of Participant Centered Service Plans updated/revised at least every 365 days or as warranted by changes in the MCWP participant's needs Numerator: Number of

Participant Centered Service Plans updated/revised at least every 365 days or as warranted by changes in the MCWP participant's needs/Denominator: Total number of MCWP participant records reviewed

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

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: Biennially	

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: Biennially

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:
#/% of MCWP participants who received services as specified in the Participant Centered Service Plan Numerator: Number of MCWP participant records that documented participant verification that services were received as specified in the Participant Centered Service Plan /Denominator: Total number of MCWP participant records reviewed

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

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: Biennially	

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: Biennially

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
#/% of Participant Centered Service Plans reviewed with documentation that MCWP participant was offered a choice among waiver services and available providers Numerator: Number of Participant Centered Service Plans reviewed with documentation that MCWP participant was offered choice among waiver services and available providers/Denominator: Total number of MCWP participant records reviewed

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

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: Biennially	

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: Biennially

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.

N/A

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.

CDPH/OA works collaboratively with the MCWP agency's Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the MCWP agency during the exit conference, and formal written SOF is provided to the MCWP agency following the review. The MCWP agency is required to submit a CAP, which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the MCWP agency appropriately addresses the findings.

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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

State law, Medi-Cal regulations, and federal regulations (WIC 10950, California Code of Regulations, Title 22, Section 51014.1 and the intent of Code of Federal Regulations, Title 42, Chapter IV, Section 431.220) require that MCWP agency agencies provide a copy of standard form MCWP4, Notice of Action (NOA) Denial/Discontinuance and State Fair Hearing Notice Request, Your Right to Appeal the NOA to all applicants at initial application and to all existing participants when they are: (1) not given the choice of home and community-based services as an alternative to institutional care; (2) denied the service(s) of their choice or the provider(s) of their choice; (3) dispute the denial, suspension, reduction or termination of one or more services; or (4) terminated/disenrolled from the MCWP. Participants are informed about the State Fair Hearing process during entrance to the MCWP via their assigned case manager. Upon initial enrollment or denial of enrollment, participants are given the standard form MCWP4.

The NOA includes information about the:

(1) Process for requesting a State Fair Hearing including the assistance available to persons pursuing a Fair Hearing, and
(2) Requirement that MCWP agency must continue providing services to participants who have submitted requests for State Fair Hearing while their requests are being addressed, provided the participants' requests are submitted within 10 days of the mailing or personal delivery of the NOA.

Each MCWP agency shall maintain a copy of each participant's completed NOA and supporting documents in each participant's file.

The California Department of Social Services (CDSS), State Hearings Division is the entity designated to conduct State Fair Hearing. During the State Fair Hearing, a participant may represent him/herself or can be represented by a friend, attorney, or any other person, but must arrange for their own representative(s). State Fair Hearings are held in the county where the petitioning participant lives. If the participant is unable to attend the hearing at the designated hearing location for reasons of poor health, the hearing may be held in the participant’s home, by telephone or in another appropriate setting.

Attendance at the hearing is ordinarily limited to the participant, participant witnesses relevant to the issue, and authorized representative and/or interpreter, if any, and normally no more than two persons from the MCWP agency, DHCS staff or attorneys may also participate as appropriate. A CDSS Administrative Law Judge shall prepare a Final Decision for the MCWP State Fair Hearing.

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.

Continually, CDPH/OA reviews all information submitted by MCWP agency or any other sources regarding participant complaints and grievances, and instances of abuse, neglect, and exploitation. The agreements between CDPH/OA and the MCWP agency require the agency to implement and maintain written grievance policies and procedures describing the submission, documentation, evaluation, and resolution of all participant grievances.

MCWP 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 CDPH/OA staff during program compliance reviews and as necessary. CDPH/OA staff consults MCWP agency on handling complaints, grievances, and complicated situations. MCWP agencies report in their biannual progress reports any complaints and grievances and their 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 still 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. If a participant has a complaint about how their benefits/services are/were handled, or their services were denied or modified, they may contact the California Department of Social Services (DSS) to request a state hearing. They may submit their request through multiple routes, including by fax, phone, online, or by mail to the county welfare department at the address shown on the Notice of Action or directly to DSS State Hearing Division. The deadlines to request an appeal were extended due to the PHE. Participants have 210 days to request a state hearing instead of 90 days.

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:

CDPH/OA.

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).

MCWP agencies must maintain and implement policies and procedures, which describe the receipt/reporting, documentation, evaluation, and resolution of grievances. Grievances are categorized into verbal complaints and written complaints.

A verbal complaint consists of any expression of dissatisfaction by a participant to MCWP agency staff in person or by telephone. For example, a participant may verbally complain that their qualified case manager does not return phone calls in a timely manner. Verbal complaints are responded to verbally by MCWP agency staff and are usually resolved quickly within 72 hours. MCWP agency staff is responsible for documenting the verbal complaint and resolution.

A written complaint is considered to be a formal complaint and consists of any written expression of dissatisfaction by a participant to MCWP agency staff. Although some MCWP agencies design forms for participants to use when submitting written complaints, use of these forms is not obligatory. When written complaints are received, MCWP agency staff must document them in the agency's complaint log. Different levels of staff may be involved in the written complaint review process.

MCWP agencies must provide written assurances that any participant who requests or needs assistance with the submission of a complaint shall receive it. MCWP agency staff presents and reviews these assurances with all participants in the document Participant Rights in Case Management at the time of enrollment and upon request. Upon completing the review of Participant Rights in Case Management, MCWP agency staff provides the participant a confirmation of receipt for signature.

All MCWP agency grievance policies and procedures must be provided 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 MCWP agency. If a participant requests to have CDPH/OA contact information provided to them, their request cannot be refused by the MCWP agency;
• Written information about the MCWP agency 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 IDTCC;
• All grievances must be reviewed at the Quality Assurance/Quality Improvement committee meeting following submission of the grievance. Appropriate action is taken as a result;
• If a verbal complaint cannot be resolved by the participant's qualified case manager, the participant must be asked if they wish to pursue it through a written complaint;
• If a verbal complaint becomes a written complaint, the MCWP agency must notify CDPH/OA of the grievance in the subsequent bi-annual progress report and provide CDPH/OA information pertaining to the case. If the grievance is resolved, the MCWP agency must notify CDPH/OA of the resolution reached or outcome;
• If a participant is unwilling to substantiate a complaint, or provide details necessary to perform an investigation, the MCWP agency is not obligated to continue investigating the complaint and/or seek resolution and may close the case. The MCWP agency shall notify the participant of its decision in writing.

The complaint and grievance processes are not prerequisites for a Request for a State Fair Hearing. A State Fair Hearing is a structured grievance process regulated by law. The complaint and grievance procedures are handled exclusively at the MCWP agency and the outcome is determined by a case manager or other administrative staff and is not bound by law.

The methods of conveyance and levels of resolution are what distinguish the complaint and grievance system from the State Fair Hearing process. The complaint system is an informal means for a client to express dis-satisfaction and can be written or communicated verbally, either face-to-face or by telephone. If the client chooses not to provide details for an investigation or pursue the complaint in writing, the client will be notified by the agency, as to whether complaint will be investigated. Resolution can come from the participant's case manager.

The written grievance is an escalation of the informal complaint. MCWP agencies are required to give notice to participants about written grievance policies at initial enrollment. The grievance policies include timelines for resolution and are evaluated by CDPH/OA personnel during every Program Compliance Review.

Participant written grievances and resolutions are documented in a grievance log and reported to the State via semi-

annual Progress Reports. MCWP agencies are required to offer assistance to clients to navigate the written grievance process.
A State Fair Hearing is a formal grievance process, mandated by federal and state law. The request for a state hearing can be written or verbal and the client can represent themselves or have an attorney, neighbor, friend, etc. as representatives, all timelines are required by law. An Administrative Law Judge is the sole decider in the State Fair Hearing process.

The complaint and grievance processes are not prerequisites for a Request for a State Fair Hearing.

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).

MCWP agencies are responsible for addressing the health and welfare needs of each MCWP participant on an on-going basis.

MCWP agency case managers are mandated reporters under California law (California Welfare and Institutions Code Section 15630(b)(1)). Case managers are required to report all incidents to the local Adult Protective Services (APS)/Child Protective Services (CPS) and law enforcement as indicated. Examples of reportable critical events or incidents include abuse (verbal, sexual, physical, or mental) or neglect; incidents posing an imminent danger to the MCWP participant, fraud or exploitation (including misuse of participant's funds and/or property), or an unsafe environment. The local county APS/CPS and/or law enforcement agency is responsible for investigating and resolving the reports.

For children, MCWP agencies must report the incident to CPS, local law enforcement, county probation departments, and county welfare departments as indicated. Reports are to be made by telephone immediately, or as soon as possible, and in writing within 36 hours of receiving information about the incident, alleged or otherwise.

For adults, MCWP agencies must report the incident to the appropriate APS and local law enforcement agency by telephone immediately, or as soon as possible, and in writing within two working days.

Incidents are identified and documented during the participant assessments, and PCSP process. MCWP agency case managers continuously monitor the progress and resolution. Ongoing monitoring of incidents, resolution strategies and outcomes are documented in the participant's assessments, progress notes and included on the PCSP.

MCWP agency will report any incidents to CDPH/OA on their biannual Progress Report including:
• Number of instances of abuse, neglect, exploitation or other critical event or incident reported for the reporting period;

• Types of abuse, neglect, exploitation, or other critical event or incident, i.e., physical, sexual, abandonment, isolation, abduction, financial, neglect, and self-neglect;
• Actions taken by MCWP staff (i.e., reports made to APS/CPS, local law enforcement, county probation department), etc. The report also identifies any teaching and/or support provided to the participant by MCWP staff; and
• Outcome and/or resolution of any reported incident indicating what could have been done to mitigate the incident before it occurred. The report also identifies actions taken by the MCWP case managers and participant in attempts to prevent/mitigate such incidents in the future.

CDPH/OA has a system in place to review reports on critical events and incidents and follow up with the MCWP agency to ensure participant health and welfare is protected. As part of the Progress Report review, CDPH/OA Nurse and Program staff review the description of the critical incident, the actions of the MCWP case management staff, and the outcome/resolution of any reported incident. CDPH/OA clinical staff will also review agencies documentation noting what could have been done to mitigate the incident before it occurred and what is being done now to prevent such incidents in the future.

Every MCWP agency shall develop, implement, and maintain its own policies and procedures for responding to incidents of abuse, neglect and exploitation. The policies and procedures required by CDPH/OA assure that there are operational procedures for managing incidents at the individual and provider level; that there are procedures in place to assure that incident reports are filed and investigated timely; that key staff are trained; and that incidents data is analyzed in order to develop strategies to reduce the risk and likelihood of the occurrence of incidents in the future and to improve the quality of services provided. These policies and procedures are in addition to what is in the law and shall include provisions from the Welfare and Institutions Code and the Penal Code.

CDPH/OA conducts follow-up and technical assistance is given during the routine Program Compliance Review at least every 24 months. Incident data is analyzed in order to develop strategies to reduce the risk and likelihood of the occurrence of instances in the future and to improve the quality of services provided.

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 MCWP agency is responsible for informing the participant and/or legal representative how to identify and report issues of abuse, neglect or exploitation that impact the health, safety, and welfare of the participant.

At the time of enrollment, the MCWP agency case manager provides the participant and/or legal representative, family members and caregivers, as applicable, with information on the types of abuse, neglect or exploitation and how to recognize these instances.

The Informed Consent/Agreement to Participate form includes information that MCWP agency staff are mandated abuse reporters. The form also provides the participant with information on self-reporting incidents of abuse, neglect and exploitation by calling 911 or contacting their county APS/CPS office. The participant and/or legal representative signs the Informed Consent/Agreement to Participate form acknowledging that they have been provided the necessary education and resources. A copy of this form is provided to the participant and one is placed in the agency's participant record.

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.

California's APS/CPS and local law enforcement have the primary responsibility to investigate and resolve the reports of incidents of abuse, neglect or exploitation as required by California law. The state uses California's Mandated Reporting laws (California Welfare and Institutions Code Section 15630(b)(1)) to ensure that all critical incidents are reported timely and appropriate follow-up occurs with MCWP agencies.

In the event of involvement of APS/CPS and local law enforcement, the MCWP agency case manager will continue to monitor the participant's health and safety to ensure the issues have been resolved.

During home visits and monthly phone calls with the participant, MCWP agency case managers ascertain whether any critical incidents have occurred and report them to the appropriate agencies (APS/CPS, law enforcement, etc.). The incident(s) are documented in the participant assessments, progress notes and added to the PCSP interventions.

Critical incidents referred to APS will, to the extent possible, be tracked by the participant's MCWP case manager at the agency. The case manager will follow up with the participant and/or authorized representative on a monthly basis (or more often as needed) to make sure that the issue has been resolved and no longer poses any risk to the participant's health, safety and welfare. If an issue is not resolved within 30 days (or by the next monthly contact) the MCWP case manager will discuss the issue with the participant and/or authorized representative and develop an alternative plan or intervention(s). This process will continue until there is no longer any risk to the participant's health, safety, and welfare.

MCWP case managers review any critical incidents with the MCWP agency Project Director.

MCWP agencies utilize Interdisciplinary Team Case Conferences to review difficult cases, including critical incidents, in order to coordinate with other agencies/entities in implementing interventions on a case-by-case basis.

Any critical incidents posing imminent danger to a participant will be reported to CDPH/OA immediately. CDPH/OA will review with DHCS/HCDS/ISCD as necessary. CDPH/OA clinical staff is available to the MCWP agencies to provide technical assistance on a case-by-case basis. Any incidents requiring technical assistance are reviewed by CDPH/OA and DHCS/HCDS/ISCD as needed during quarterly meetings or sooner as warranted.

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.

CDPH/OA is the State agency responsible for overseeing the reporting of and response to critical incidents and/or events that affect MCWP participants. CDPH/OA utilizes a process for tracking the reporting, documentation, remediation, and outcome of critical incidents and events.

MCWP agencies report the total number of incidents encountered on the biannual Progress Report. Upon receipt of the biannual reports, CDPH/OA clinical staff contacts MCWP agencies to clarify any necessary information, identify whether the event is a repeated incident and discuss MCWP agency actions taken in response to the event. The outcome/resolution of incident is also discussed including investigations of APS/CPS reports (if shared). CDPH/OA clinical staff will provide technical assistance as needed.

CDPH/OA has made changes to the MCWP biannual Progress Report, so that all critical incidents, including processes, timelines, and follow-up are submitted for review. Since California's APS/CPS program does not consistently disclose report outcomes due to confidentiality, CDPH/OA reviews MCWP agency and participant reported outcomes on a biannual basis, with the expectation that the MCWP agencies are monitoring and responding to all critical incidents on a monthly basis at a minimum.

CDPH/OA will aggregate and analyze the biannual report data to summarize for DHCS/HCDS/ISCD review. CDPH/OA identifies trends and develops strategies for applying interventions as required. If trends are identified, the MCWP agencies will be notified, and training will be provided to MCWP agency staff.

During biennial Program Compliance Reviews, CDPH/OA reviews participant record assessments, progress notes and PCSPs. CDPH/OA clinical staff cross-references critical incidents reported on the MCWP biannual Progress Report, then conducts case record reviews to determine:
• If the MCWP case managers are completing and submitting APS/CPS referrals in a timely manner for all events that may or are affecting the participant's health and safety;
• If an appropriate action plan was developed and documented in the participant assessments, progress notes and PCSP as applicable;
• That critical incident issues continue to be monitored during ongoing case management calls and home visits, until the participant reports the issue(s) has been resolved; and
• If systemic program issues exist that require remediation.

If deficiencies are identified in the participant's records regarding health and welfare issues during the Program Compliance Review, a written report of the findings and recommendations is issued to the MCWP agency from CDPH/OA. This report will include a formal written request for a CAP specific to remediating the deficiencies. The MCWP agency is required to respond to CDPH/OA and develop a formal plan to cover any deficiencies identified; the plan is then monitored by CDPH/OA. Technical assistance is provided as needed.

CDPH/OA tracks data in search of health and welfare issues using the data from both the biannual Progress Reports and the Program Compliance Review. CDPH/OA analyzes data to identify trends of critical incidents or events. If identified, CDPH/OA evaluates the trend(s) to determine if changes in program guidance, policy or requirements are necessary. CDPH/OA shall provide regional and/or statewide trainings and follow-up with MCWP agencies as necessary.

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 MCWP agencies are responsible for ongoing monitoring and ensuring the health, safety and welfare of MCWP participants including ensuring that restraints are not utilized under any circumstances. The MCWP case managers will monitor the participant's health and safety at both the monthly face-to face or telephonic visits and every 365 days reassessments. CDPH/OA provides oversight during the compliance review process.

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).

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:

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 MCWP agencies are responsible for ongoing monitoring and ensuring the health, safety and welfare of MCWP participants including ensuring that restrictive interventions are not utilized under any circumstances. The MCWP case managers will monitor the participant's health and safety at both the monthly face-to face or telephonic visits and every 365 days reassessments. CDPH/OA provides oversight during the compliance review process.

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 MCWP agencies are responsible for ongoing monitoring and ensuring the health, safety and welfare of MCWP participants including ensuring that use of seclusion is not utilized under any circumstances. The MCWP case managers will monitor the participant's health and safety at both the monthly face-to face or telephonic visits and every 365 days reassessments. CDPH/OA provides oversight during the compliance review process.

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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

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.

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:
#/% of MCWP participant records reviewed which included documentation that risk

for abuse, neglect and exploitation was assessed by the case management team Numerator: Number of MCWP participant records reviewed that included documentation that risk for abuse, neglect and exploitation was assessed by the case management team/Denominator: Total number of MCWP participant records reviewed

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

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: Biennially	

Data Aggregation and Analysis:

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

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

Performance Measure:
#/% of MCWP participant records reviewed which included documentation that a Home Environment Assessment was completed in accordance with MCWP requirements Numerator: Number of MCWP participant records reviewed which included documentation that a Home Environment Assessment was completed in accordance with requirements/Denominator: Total number of MCWP participant records reviewed

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

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: Biennially	

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: Biennially

Performance Measure:
#/% of participant records reviewed that included documentation that the participant, family/support are aware of how to report instances of abuse, neglect or exploitation Numerator:#of MCWP participant records containing documentation that the participant, family/support are aware of how to report instances of abuse, neglect or exploitation/Denominator:Total # of MCWP participant records reviewed

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

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: Biennially	

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: Biennially

Performance Measure:
#/% of Critical incidents, specifically occurrences of abuse, neglect, exploitation and suspicious death reported to the appropriate investigative entities within the required timeframe Numerator: Number of critical incidents reported in the required timeframe/Denominator: Total number of critical incidents reported

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bi-annual Progress Report reviews and Record reviews, on-site and/or electronic

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: Semi-annually for Progress Reports Review; Biennially for on-site or electronic record reviews	

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: Semi-annually for Progress Reports Review; Biennially for on-site or electronic record reviews

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:
#/% of MCWP participants who denied having a recurrence of similar critical incidents after interventions were implemented Numerator: Number of MCWP participants who denied having a recurrence of similar critical incidents/Denominator: Total number of critical incidents reported

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bi-annual Progress Report reviews and Record reviews, on-site and/or electronic

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: Semi-annually for Progress Reports Review; Biennially for on-site or electronic record reviews	

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: Semi-annually for Progress Reports Review; Biennially for on-site or electronic record reviews

Performance Measure:

#/% of Critical incidents reported that have been effectively resolved as reported by the MCWP participant Numerator: Number of MCWP participants who reported critical incidents have been effectively resolved/Denominator: Total number of critical incidents reported

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bi-annual Progress Report reviews and Record reviews, on-site and/or electronic

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: Semi-annually for Progress Reports Review; Biennially for on-site or electronic record reviews	

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: Semi-annually for Progress Reports Review; Biennially for on-site or electronic record reviews

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.

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.

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.

N/A

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.

CDPH/OA works collaboratively with the MCWP agency’s Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site and/or electronic review. All substantive findings are discussed with the MCWP agency during the exit conference, and formal written SOF is provided to the MCWP agency following the review. The MCWP agency is required to submit a CAP, which remediates all identified findings. CDPH/OA reviews the CAPs and provides ongoing monitoring to ensure the MCWP agency appropriately addresses the findings.

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**

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

CDPH/OA performs an ongoing sampling of MCWP participant records through its discovery process, the PCR. The CDPH/OA compliance review team analyzes case records, progress notes, assessment/reassessments, the PCSP, and any other pertinent documentation. The analysis of these records allows the PCR team to determine that documentation was completed on a timely basis, with the appropriate forms, by appropriate personnel. The areas of review include Level of Care, care plan, provider services and participant health and welfare.

When an individual problem is identified during the PCR process, a written report of the findings and recommendations is issued to the site from CDPH/OA that will include a formal written request for a CAP specific to remediating the problem. The MCWP agency is required to respond to CDPH/OA 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 CAP will be completed. The CAP and associated actions are monitored by CDPH/OA and upon successful remediation of the problem the CAP is approved. Technical assistance is provided throughout the process and on an as-needed basis.

Should a specific site have significant issues CDPH/OA would require in writing that the site develop a CAP specific to correcting the issue(s). The site would be required to respond to CDPH/OA 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 would be monitored by CDPH/OA and upon successful remediation of the problem, the CAP would be approved. Technical assistance would be provided throughout the entire issue resolution process.

CDPH/OA aggregates the results of the site PCR discovery information. Aggregate data regarding MCWP enrollment, PCSP, trends and significant deficiencies, SOF Reports, and CAP is reviewed with DHCS/HCDS/ISCD at quarterly meetings. Policy revisions and updates are disseminated through MCWP Protocols and Program Operation Manual and through policy clarification letters.

CDPH/OA also provides technical assistance through on-going email and telephone contact between the MCWP agency and CDPH/OA staff. CDPH/OA uses this aggregate data to prioritize training needs in order to schedule multi-site training events.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Quality Improvement Committee	**Annually**
Other Specify:	**Other** Specify: Ongoing

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 PCRs performed after CDPH/OA's remediation activities are analyzed in order to measure their effectiveness. This analysis may result in system changes to the PCRs and PCR tools and to methods of policy dissemination, technical assistance and training.

CDPH/OA analyzes and aggregates the findings from PCRs and ranks the findings according to significance. CDPH/OA staff develops strategies for training and technical assistance. CDPH/OA staff follow-up with MCWP agencies after the training is completed to measure efficacy of training.

CDPH/OA and DHCS/HCDS/ISCD discuss potential trends identified and implement additional technical assistance and remediation plans as warranted.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Every 12 months, preceding the submission of the CMS 372, DHCS and CDPH review the quality assurance system to assess whether the systems are identifying areas needed for quality improvement initiatives. By reviewing and updating performance metrics to assess whether changes are actually leading to improvement, DHCS and CDPH promote continuous quality improvement for the Waiver. System changes are identified and mutually agreed upon between DHCS and CDPH. The PCR tool is changed to reflect mutually agreed upon revisions.

Quality improvement input is also solicited from the MCWP agencies during the scheduled collaborative teleconferences between CDPH and MCWP agencies.

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 A&I, Financial Audits Branch shall ensure the fiscal integrity of the health programs administered by DHCS, its MCWP programs and affiliated Departments, to promote the quality of care provided to the beneficiaries of these programs through financial audits and in accordance with applicable laws, regulations, and program intent.

CDPH/OA makes referrals to DHCS/HCDS/ISCD, who in turn, forwards to DHCS Audits and Investigation requesting that audits of a particular MCWP agency be performed if there is a question about fiscal practices at the agency.

State Methods to Ensure Integrity of Provider Billings:
In order to claim reimbursement, an agency which chooses to be an organized health care delivery system in accordance with Appendix I-3, section (g)(2), must first obtain active status from DHCS Provider Enrollment Branch using the CDPH 8545, MCWP, Medi-Cal Provider Application. Federal regulations require Medicaid programs to ensure program integrity by requiring that providers disclose certain information. The Medi-Cal program attempts to deter potential fraud and abuse by requiring providers to complete the DHCS 6207, Medi-Cal Disclosure Statement form. The provider applicant declares under penalty of perjury under State laws that all information disclosed is true and accurate. The Medi-Cal Provider Enrollment Branch reviews all disclosures. If information disclosed is questionable and believed to result in fraud and/or abuse of Medi-Cal funds, follow-up is made and/or the application is denied. These application forms are submitted via CDPH/OA to the Payment Systems Division, DHCS for processing.

All providers of services to Medi-Cal beneficiaries must be enrolled as a Medi-Cal provider as required under state and federal Medicaid provider enrollment laws, including but not limited to:
- *42 U.S.C. 1396a(78),*
- *42 CFR Part 455, Subpart E,*
- *Welfare & Institutions Code, Division 1, Part 3, Chapter 7, Article 1.3,*
- *CCR, Title 22, Division 3, Subdivision 1, Article 1, and*
- *Applicable Medi-Cal Provider Enrollment Bulletins.*

MCWP agencies submit participant-related information including level of care (see Appendix B-6) to CDPH/OA. CDPH/OA confirms that participants are Medi-Cal eligible and not currently enrolled in the MCWP, then issues a participant specific MCWP identification number confirming their enrollment. All claims use MCWP specific procedure codes.

Medi-Cal pays MCWP agencies a flat monthly fee for case management services per eligible enrolled MCWP participant. All other MCWP services are reimbursed at cost, but not in excess of the rates established in the MCWP Program Rate Schedule.

Each MCWP agency is required by agreement to develop, implement, and maintain written fiscal policies and procedures that address:

- *Tracking of services ordered, billed, and delivered;*
- *Tracking of costs of services for each participant to assure that the annual $33,937 maximum allowable reimbursement for each participant is not exceeded;*
- *Separation of duties for accounting staff responsible for accounts payable and receivable;*
- *Identification of expenditures by program, program components, and/or budgetary category; and*
- *The preparation and availability of financial statements for case management staff (for participant services portion) and the board of directors, or county board of supervisors, on a monthly basis.*

Additionally, the following financial performance indicators are reviewed during the CDPH/OA Program Compliance Reviews conducted at least every 24 months at each MCWP agency:
- *Licensing and certification of providers;*
- *Subcontracts with providers of direct care services;*
- *Direct care services ordered were actually delivered and accurately billed;*
- *Claims were submitted and paid in a timely manner;*
- *Only claims for Medi-Cal eligible participants enrolled in the MCWP were paid;*
- *Cost avoidance and resource evaluation are being overseen by qualified case managers and documented in the participant record;*
- *Vouchers/expenditures for nutritional supplements and transportation vouchers/expenditures are tracked separately by participant, date, and amount; and*
- *Qualified case manager staff-to-participant ratios meet CDPH/OA requirements; Full Time Equivalent (FTE) per program is documented and is accurate.*

Prior to each biennial PCR, CDPH/OA staff requests the current and recently discharged list of participants sorted by case managers from the agency. In addition, CDPH/OA will request the agency billing from DHCS/HCDS/ISCD. A random representative sample of participant records for review is chosen. During the PCR, a CDPH/OA Registered Nurse and Program Advisor review participant billing records to determine: a) if the billed services are medically necessary and listed in the PCSP; and b) if the medically necessary services provided are billed.

CDPH/OA program advisors request the current and recently discharged list of participants sorted by case managers from the agency. CDPH/OA program advisors request the current and recently discharged list of participants sorted by case managers from the agency. CDPH/OA clinical staff select a random representative sample of a minimum of 10 records (if applicable) or 22.11% of the total records for review.

If a site contains more than one case management team, an equal number of records are selected to represent the work of each team or individual case manager. The sample is divided into three categories: a) participants newly enrolled during the review period, b) currently active participants and those enrolled prior to review period, and c) participants recently discharged for reasons other than death. Clinical staff will also review billing provided by DHCS/HCDS/ISCD to identify any heavy service utilizers and include them in the sample.

Program Compliance Reviews are conducted for each agency every 24 months. A team from CDPH/OA conducts the review. A Program Advisor and Registered Nurse perform the record review portion of the review, which includes reviewing the participant records. A program advisor conducts the contract monitoring review, which includes review of agency policies and procedures, subcontracts, and agency personnel files.

During each biennial program compliance review, CDPH/OA staff review the subcontracts to make sure that the payment rate matches the MCWP billing rate listed in the Medi-Cal Outpatient Services Manual. If the payment rate specified in the contract between the MCWP agency and the subcontractor differs from the rate in the Outpatient Services Manual, then a finding is issued in a SOF Report within 30 days and the agency must then submit a CAP to amend this finding within 30 days.

During Program Compliance Reviews, CDPH/OA staff reviews a sampling of MCWP agency and participant records to assure adequate documentation exists to validate provider billings and that billings were accurately made. Invalid or inaccurate claim submittals are automatically denied and the provider notified through a Remittance Advice Detail (RAD). Paid claims that are not valid or accurate, based on the MCWP agency agreement with CDPH/OA or an audit finding, may be recovered by the State and/or Federal Government.

The formal Contract Monitoring and Record Review SOF Reports are provided from CDPH/OA to the agency and DHCS/HCDS/ISCD within 30 days of each biennial Program Compliance Review. Agencies are required to provide CAPs for all findings listed in the SOFs and submit to CDPH/OA within 30 days of the receipt of the SOF reports. CDPH/OA provides feedback to CAPs and requests corrections if necessary, provides technical assistance and performs follow-up visits as needed.

MCWP agency bi-annual Progress Reports submitted to CDPH/OA include the following financial reporting:

• Existing, new, and terminated subcontractors by name, type of service provided, licenses and/or certifications (if applicable), and effective dates of the subcontract;
• Plans for replacing terminated subcontracts/services if necessary, to meet requirements; and
• Requests for technical assistance in billing, budget issues, and policy and procedure development; and
• All MCWP agencies are required to submit a Single Audit (annual independent audits of financial statements) and must comply with the Single Audit Act and the audit reporting requirements set forth in Uniform Guidance.

DHCS/HCDS/ISCD staff reviews paid claim data to monitor utilization of services. Reports are analyzed to determine the following:
• Lack or gaps in billing;
• Timeliness of paid claims;
• Correct utilization of rates and codes, as specified by waiver requirements;
• Tracking participant's costs compared to the Waiver services cap;
• Types and units of service billed; and
• Comparisons with statewide average billing per participant (total billed and by service).

Electronic Visit Verification
Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies in-home service visits. EVV systems are used to verify the type of service being provided; the individual receiving the service; date of the service; location of service delivery; the individual providing the service; and the time the service begins and ends.

California is implementing two Electronic Visit Verification (EVV) systems, known as EVV Phase I and EVV Phase II. EEV Phase I was implemented on January 1, 2022 and providers of Medi-Cal home and community-based personal care services (PCS) must be registered, trained, and using either the CalEVV system or an alternate EVV system. EVV Phase II for home health care services is anticipated to be implemented by January 1, 2023.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
#/% of MCWP claims using the correct rates and codes as specified by the waiver requirements Numerator: Number of MCWP claims using the correct rates and codes/Denominator: Total number of MCWP claims submitted

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100%**

		Review
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =* *95% +/- 5%*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*
	Continuously and Ongoing	***Other*** *Specify:*
	Other *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
#/% of Consistent reimbursement rates based on MCWP rate methodology Numerator: Consistent reimbursement rates reviewed/Denominator: Total billing sample sized 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:
#/% of financial audits that warranted recovery that resulted in recoupment of Waiver funds. Numerator: Number of financial audits that warranted recovery that resulted in recoupment of Waiver funds. Denominator: Total number of financial audits that warranted recovery.

***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 =*

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.*

N/A

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.*

CDPH/OA works collaboratively with the MCWP agency's Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the MCWP agency during the exit conference, and a formal written SOF is provided to the MCWP agency following the review. The MCWP agency is required to submit a CAP, which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to confirm the MCWP agency appropriately addresses the findings.

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).*

MCWP agencies bill for MCWP services based on the maximum allowable rate, which is detailed in the rate sheet found in the Medi-Cal Provider Manual:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/aidsbilcd.pdf

In 1989, at program inception, DHCS determined MCWP service rates by first comparing and analyzing actual rates paid statewide in local communities. From these results, statewide maximum reimbursable rates were set for each service. For example, the monthly case management fee is determined by surveying MCWP agencies to collect information on staff salaries, number of hours spent monthly performing case management and administrative activities. To maintain cost effectiveness, a monthly and/or annual cap for some services and a maximum annual participant cap were set. Staff- to-participant ratios were also determined. A built-in cost-of-living (percentage) increase was implemented in 1990 and 1991. Additionally, the Homemaker and Attendant Care Service rates were increased in a previous amendment to adjust for minimum wage increases. Assembly Bill 120, which was signed by the California Governor on June 27, 2017, appropriated funds for the purposes of increasing rates for MCWP services paid to MCWP agencies. The appropriation will be applied to increase the payment rates for attendant care, enhanced case management, homemaker, non-medical transportation, nutritional counseling, psychotherapy, and skilled nursing services. DHCS worked with MCWP stakeholders to identify sufficient percentage increases to apply to each MCWP service. These percentage increases were vetted through the stakeholder process for AB 120 and Proposition 56. This does not result in a change to the rate methodology.

Most adjustments to rates are tied to the annual provider coding guidance which clarifies the payment rates for each procedure code (HCPCS) on an annual basis (which may adjust codes/rates across multiple services and provider types), or other state/federal authorized/mandated adjustments. DHCS/HCDS/ISCD, in collaboration with Fee-For-Service Rates Development Division (FFSRDD), develops a policy justification for rate changes, outlines authorities relevant and needed to adjust the rates, and works with the fiscal intermediary to update rates.

The State provides a 30-day Public Comment Period when proposing rate methodology adjustments. A notice is published in the California Register, and MCWP agencies are notified through letters to the agency Directors. MCWP agencies inform their contractors and beneficiaries. The proposed rates are posted on CDPH/OA's Medi-Cal Waiver Program webpage or may be mailed if requested.

The State includes three distinct psychotherapy services; however, the rates paid for each psychotherapy service is the same. These three psychotherapy services have distinct codes due to the setting/manner in which the service is being provided. What does not change is the actual service provided, the qualified provider type to deliver the service, or the timeframe in which the service is measured for billing. This is a unit of therapy that can either be delivered individually to the MCWP participant, separately to the MCWP participant family, or to the family with MCWP participant present. The purpose of the three different codes is to more easily track the specific types of therapy rendered as there is no difference in cost of service unit across the three codes.

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:*

1. Direct care service providers submit invoices to the MCWP agency; who review the invoices to determine if the service(s), date(s), frequency, and amount(s) billed are accurate.

2. The MCWP agency submits claims, which include subcontractor expenditures and MCWP agency case management fees, to DHCS' Medicaid Management Information System (MMIS) fiscal intermediary. The frequency of claim submission varies by MCWP agency, e.g., semi-weekly, monthly, quarterly.

3. The fiscal intermediary pays MCWP agencies based upon the claims submitted.

4. MCWP agencies reimburse subcontractors within 30 days of receipt of payment from the fiscal intermediary.

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:*

1. The MMIS has edits in place to prevent payment for ineligible individuals. All eligible individuals must be on the MCWP participant file, which is cross referenced when adjudicating claims through the MMIS. The fiscal intermediary performs routine and ad hoc claim reviews to assure that payment is only made when the individuals were eligible for Medicaid waiver payment.

2. The MCWP agency qualified case manager, Project Director, and/or fiscal officer review billings to assure that services are included in the approved PCSP, and to verify the accuracy of the services utilized, amount billed, and date(s) services were provided.

3. During Program Compliance Reviews, CDPH/OA staff reviews a sampling of MCWP agency and participant records to assure adequate documentation exists to validate provider billings and that billings were accurately made. Invalid or inaccurate claim submittals are automatically denied and the provider notified through a Remittance Advice Detail (RAD). Paid claims that are not valid or accurate, based on the MCWP agency agreement with CDPH/OA or an audit finding, will be recovered by the State and/or Federal Government. When providing reimbursement data to CMS, DHCS produces data reports that will contain only the last amount paid. When adjustments are made on a particular claim, those adjustments will be accounted for when determining the final paid amount on the claim.

4. During Program Compliance Reviews, CDPH/OA clinical staff review participant assessments to confirm that all medically necessary services are listed in the PCSP. Services identified on the PCSP are compared against billing records to substantiate the scope and amount of services have been provided.

5. MCWP agencies are required to submit a copy of their single, organization-wide, financial and compliance audit, as needed per fiscal year.

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:

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:

Several MCWP providers are local county governments. They receive the same monthly flat case management reimbursement per participant for administering the MCWP and providing case management as received by all MCWP agencies. All providers of case management receive the maximum allowable per the fee schedule.

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 MCWP Agency – Any local county government or community-based organization may apply to become an MCWP agency. To be considered, an interested party must submit a Letter of Intent to CDPH/OA indicating its interest in becoming an MCWP agency. Through evaluative methods, CDPH/OA determines if these agencies meet requirements to become MCWP agencies. The applicant must identify effective date and counties to be served, a statement that becoming an MCWP agency is cost and administratively feasible, estimated monthly and annual number of participants eligible for MCWP, and the steps to be taken to assure maintenance of estimated MCWP caseload.

Provider Number – Each agency must obtain a National Provider Identifier (NPI) before applying to become an MCWP provider. Agencies must complete the AIDS Medi-Cal Waiver Program Medi-Cal Provider Application portion of form CDPH 8545. The completed form must then be submitted to the CDPH/OA.

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. The DHCS 6207 is submitted to the Payment Systems Division, DHCS for processing.

All providers of services to Medi-Cal beneficiaries must be enrolled as a Medi-Cal provider as required under state and federal Medicaid provider enrollment laws, including but not limited to:
- *42 U.S.C. 1396a(78),*
- *42 CFR Part 455, Subpart E,*
- *Welfare & Institutions Code, Division 1, Part 3, Chapter 7, Article 1.3,*
- *CCR, Title 22, Division 3, Subdivision 1, Article 1, and*
- *Applicable Medi-Cal Provider Enrollment Bulletins.*

Provider Qualifications /Requirements - The agreement model between CDPH/OA and MCWP agencies contains provider qualifications and all other applicable requirements.

Payment - DHCS's fiscal intermediary pays MCWP agencies monthly case management fees, per eligible enrolled MCWP participants. All other MCWP services are reimbursed at cost, but not in excess of the rates published in the MCWP Program Billing Codes and Rates section of Part 2 of the Medi-Cal Inpatient/Outpatient Manual. Direct care service providers invoice the MCWP agency for services rendered. The MCWP agency submits claims to the State's MMIS fiscal intermediary. The MCWP agency reimburses the subcontractor within 30 days of receipt of payment from the fiscal intermediary.

Informing New Enrollees – Once an individual is determined eligible to enroll in the MCWP, a qualified case manager describes the MCWP services, limitations, requirements, and any feasible alternative programs to him/her, including the option of being institutionalized as compared to receiving home and community-based services through the MCWP. The qualified case manager answers any questions the interested individual/applicant may have.

The qualified case manager then presents and explains the Informed Consent/Agreement to Participate and MCWP Notice of Action: Your Right to State Fair Hearing standard forms to the applicant. Prior to enrollment/development of the PCSP, the qualified case manager answers any questions the applicant/interested individual may have.

Enrollment and Selections – In order to participate in the MCWP, an applicant or their legal representative, must sign the Informed Consent/Agreement to Participate form, initialing and dating the acknowledgment of rights and responsibilities, grievance procedures, and the Notice of Action. The applicant must also choose between receiving services under the MCWP or other care/institutionalization at the time of enrollment. The applicant is then provided the opportunity to choose their direct care providers.

Licensing and Certification Standards – MCWP agencies are required to establish and implement policies and procedures to assure that their staff, providers, and provider staff meet licensing and/or certification standards and adhere to other state requirements. Some providers are required to be licensed and others only require certification. Specifically:

• Licensing and Certification is required for all MCWP agencies that provide hands-on care;
• Licensing and Certification is not required for trained individuals providing homemaker services as they do not provide hands-on care. Subcontracted providers conduct a basic orientation on HIV/AIDS, infection care, confidentiality and Abuse, Neglect and Exploitation to trained individuals providing homemaker services;
• MCWP agencies oversee licensed and non-licensed/non-certified providers to assure adherence to state and federal regulations regarding monitoring visits by RNs; and
• Exemptions require prior written approval from CDPH/OA. Exemptions may consist of the following staff qualifications when appropriate credentialed staff is not available for hire in the local area. Appropriate supervision is provided by individuals meeting the credential requirement. MCWP agency Requirements – MCWP agencies are required to:
• Have a system in place to verify provider and provider staff qualifications, training and licensure prior to any service being provided to participants and periodically thereafter; and
• Use model subcontract language to assure these requirements are met for providers and provider staff.

Monitoring of MCWP agency Subcontractors - CDPH/OA requires MCWP agencies to have systems in place for monitoring subcontractor staff orientation, training and licensure (i.e., current licensure, appropriate contract language/requirements, appropriate rates). This is a required element of the agreement between CDPH/OA and MCWP agencies that guarantees compliance prior to services being provided.

In extenuating circumstances, individual MCWP agencies can request a Direct Care Service (DCS) Exemption from CDPH/OA to provide direct care services to participants instead of using a subcontractor to provide services. DCS exemption requests are reviewed and considered on a case-by-case basis. Otherwise, agencies are expected to subcontract with a minimum of three providers for each service to facilitate participant choice. In some circumstances there may not be adequate subcontractors to provide services; therefore, agencies can request a DCS exemption from OA to provide the service(s) directly to participants.

Local providers are offered the opportunity to contract with an MCWP agency. They Local providers may provide services as long as they are determined by the MCWP agency to have enrolled as a Medi-Cal provider, to be a qualified waiver provider based on the provider qualifications outlined in the waiver application, and that they are willing to certify that they will accept the rates specified in the waiver. MCWP agencies are responsible for prior authorization of all MCWP services and for verification that the requested services are in accordance with the participant's current plan of care and are medically necessary. MCWP agencies are also responsible for submission of all claims for services performed by MCWP Providers whether contracted or independent and shall comply with the reimbursement protocols outlined in the MCWP Medi-Cal Provider Manual.

Local providers contract with MCWP agencies for several reasons. The primary reason is to ensure the confidentiality of protected health information for the sensitive population served by the MCWP. Standard MCWP agency subcontracts are required to contain HIPAA compliant business associate agreements that fully outline secure data transmission requirements, require implementation of processes designed to secure protected health information and clearly detail reporting requirements in the event of a breach. The contract also fully details the provider enrollment process and requirements and contains provisions establishing requirements for timely payment of claims. State contracting law requires primary contractors to have signed contracts with subcontractors in order to be able to legally enforce these and other terms and conditions inherent in the business relationship. Exhibit A, Provision 9. H of the current contract between CDPH and the MCWP agencies states, "Subcontracts for MCWP services must be signed by both the Contractor and subcontractor before services are provided. Subcontracts are subject to OA review and/or approval." Additionally, Exhibit D, Provision 5 has the following requirements of the MCWP agencies:

5.d – Contractor shall maintain a copy of each subcontract entered into in support of the Agreement and shall, upon request by CDPH, make copies available for approval, inspection and audit.
5.e – CDPH assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this agreement.
5.f – The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

5.g – The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this agreement.

These provisions would be unenforceable if no formal contract was in place between the MCWP agencies and the subcontractors, thereby placing both the MCWP agency and the State legally at risk in the event of data breaches, misconduct, compromised participant safety, poor performance, etc.

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state

entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

Not Applicable*. There are no local government level sources of funds utilized as the non-federal share.*

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that*

make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Each MCWP service has a unique billing code. Residential facility room and board is not a billable MCWP service.

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

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	4405.95	26158.00	30563.95	108838.00	29511.00	138349.00	107785.05
2	4579.87	25556.00	30135.87	113115.00	29511.00	142626.00	112490.13
3	4765.27	24968.00	29733.27	117561.00	29511.00	147072.00	117338.73
4	4959.73	24394.00	29353.73	122181.00	29511.00	151692.00	122338.27
5	5153.51	23833.00	28986.51	126983.00	29511.00	156494.00	127507.49

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
Year 1	1948	468	1480
Year 2	1948	468	1480

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:	*Level of Care:*
		Hospital	*Nursing Facility*
Year 3	*1948*	468	1480
Year 4	*1948*	468	1480
Year 5	*1948*	468	1480

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 Average Length of Stay (ALOS) is based on the average ALOS for Calendar Years 2017, 2018, and 2019. ALOS: 311/365
- *2017: 305.50*
- *2018: 315.80*
- *2019: 310.90*

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:*

Estimated Number of Users: The number of unduplicated participants for each waiver year of this renewal was estimated using a baseline of 1137 clients and an average annual increase of 4%. The 4% growth rate of MCWP participants is based on projected increases in the provider network and waiver capacity. The baseline 1,137 client count in Waiver Year 1 is based on Waiver Year 5 of the previous waiver actual enrollment data plus an additional 4% and allows for extra capacity in order to avoid disenrollments and waiting lists at waiver agencies.

Avg. Units/User: The utilization percentages were developed by calculating the percent of participants that utilized each service in 2017, 2018, and 2019 based on MIS/DSS claims data. The percent utilization was applied to the projected participants going forward for 2023-2027. This methodology was chosen because the annual projected participant count was provided.

Avg. Cost/Unit: Actual average of cost per beneficiary over Waiver years 2017, 2018, and 2019 for each service category.
Total Cost: Estimated Number of Users multiplied by the Avg. Units/User multiplied by the Cost/Unit.

Factor D’ and G’ were estimated by averaging the 2017, 2018, and 2019 cost per bene for Factor D’ and G’ as reported in the 372 reports. Between 2017 and 2019 Factor D’ was consistently reported less than Factor G’.

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:*

Factor D' is based on the average actual costs through the CMS 372 report during calendar years 2017, 2018, and 2019. The State determined an average ongoing decrease in costs of 2.3% from 2017 - 2019. Waiver Year 1 Factor D' costs is the 2019 baseline cost less 2.3%, and this decrease in cost is applied across the five waiver years. The 2.3% trend for Factor D' was estimated by calculating the average percent change of the cost per bene for Factor D' between 2017 and 2019.

The costs were compiled from the 2017, 2018, and 2019 CMS 372 paid claims reports, to report utilization and expenditures of waiver services and State Plan expenditures of participants enrolled.

This calculation is performed for each level of care (Acute/NF) and the weighted average is completed in Appendix J-1.

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 was based on a modified methodology by calculating the average cost per person in NF and HIF levels of care excluding the minimum 180 day requirement. The 180 day requirement was removed because it didn't align with the needs of the waiver participants. This methodology is more in alignment with published NF-B rates that project around $90K in annual expenditures if all waiver participants were at the NF-B level of care. The average cost for peer group data was being skewed to appear higher because only the most acute individuals were being counted. By removing the 180 day stay requirement, the peer group expands and more closely resembles our waiver beneficiaries.

The State determined a 3.93% average increase from 2017-2019 and applied this increase to the 5-year waiver estimates. The 3.93% trend for Factor G was estimated by calculating the average percent change of the reported cost per bene for Factor G between 2016 and 2019.

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:*

Factor G' is based on the average total cost of health care furnished, in addition to the institutional costs in Factor G, for Waiver years 2017, 2018, and 2019. Over Waiver years 2017-2019, the average cost per beneficiary was $29,426 (2017), $31,096 (2018), and $28, 011 (2019).

The costs were compiled from the CMS 372 paid claims reports, to report utilization and expenditures of services and State Plan expenditures of participants enrolled during Waiver years 2017, 2018, and 2019.

This calculation is performed for each level of care (NF/Acute) and the weighted average is completed in Appendix J-1.

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	
Enhanced Case Management	
Homemaker	
Skilled Nursing, Licensed Vocational Nurse	
Skilled Nursing, Registered Nurse	
Attendant Care	
Home-Delivered Meals / Nutritional Supplements	
Medi-Cal Supplements for Infants and Children in Foster Care	

Waiver Services	
Minor Physical Adaptations to the Home	
Non-Medical Transportation	
Nutritional Counseling	
Psychotherapy	
Specialized Medical Equipment and Supplies	

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
Enhanced Case Management Total:						4096885.70
Enhanced Case Management	Month	1137	9.92	363.23	4096885.70	
Homemaker Total:						2616738.57
Homemaker	15 Minutes	279	1326.59	7.07	2616738.57	
Skilled Nursing, Licensed Vocational Nurse Total:						4872.04
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	5	69.75	13.97	4872.04	
Skilled Nursing, Registered Nurse Total:						6114.76
Skilled Nursing, Registered Nurse	15 Minutes	4	79.33	19.27	6114.76	
Attendant Care Total:						471590.43
Attendant Care	15 Minutes	51	971.31	9.52	471590.43	
Home-Delivered Meals / Nutritional Supplements Total:						572199.52
Home-Delivered Meals / Nutritional Supplements	Month	800	14.03	50.98	572199.52	
Medi-Cal Supplements for Infants and Children in Foster Care Total:						4056.00
Medi-Cal Supplements for	Month	1	12.00	338.00	4056.00	
GRAND TOTAL:						8582794.04
Total Estimated Unduplicated Participants:						1948
Factor D (Divide total by number of participants):						4405.95
Average Length of Stay on the Waiver:						311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Infants and Children in Foster Care						
Minor Physical Adaptations to the Home Total:						107.92
Minor Physical Adaptations to the Home	Year	3	0.41	87.74	107.92	
Non-Medical Transportation Total:						387780.00
Non-Medical Transportation	Month	460	8.43	100.00	387780.00	
Nutritional Counseling Total:						162.84
Nutritional Counseling	Hour	1	2.56	63.61	162.84	
Psychotherapy Total:						412013.35
Psychotherapy	Hour	126	33.36	98.02	412013.35	
Specialized Medical Equipment and Supplies Total:						10272.91
Specialized Medical Equipment and Supplies	Year	23	3.96	112.79	10272.91	
GRAND TOTAL:						8582794.04
Total Estimated Unduplicated Participants:						1948
Factor D (Divide total by number of participants):						4405.95
Average Length of Stay on the Waiver:						311

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
Enhanced Case Management Total:						4259031.57
Enhanced Case Management	Month	1182	9.92	363.23	4259031.57	
Homemaker Total:						2719907.48
Homemaker					2719907.48	
GRAND TOTAL:						8921588.67
Total Estimated Unduplicated Participants:						1948
Factor D (Divide total by number of participants):						4579.87
Average Length of Stay on the Waiver:						311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minutes	290	1326.59	7.07		
Skilled Nursing, Licensed Vocational Nurse Total:						4872.04
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	5	69.75	13.97	4872.04	
Skilled Nursing, Registered Nurse Total:						6114.76
Skilled Nursing, Registered Nurse	15 Minutes	4	79.33	19.27	6114.76	
Attendant Care Total:						490084.17
Attendant Care	15 Minutes	53	971.31	9.52	490084.17	
Home-Delivered Meals / Nutritional Supplements Total:						594372.25
Home-Delivered Meals / Nutritional Supplements	Month	831	14.03	50.98	594372.25	
Medi-Cal Supplements for Infants and Children in Foster Care Total:						4056.00
Medi-Cal Supplements for Infants and Children in Foster Care	Month	1	12.00	338.00	4056.00	
Minor Physical Adaptations to the Home Total:						107.92
Minor Physical Adaptations to the Home	Year	3	0.41	87.74	107.92	
Non-Medical Transportation Total:						403797.00
Non-Medical Transportation	Month	479	8.43	100.00	403797.00	
Nutritional Counseling Total:						162.84
Nutritional Counseling	Hour	1	2.56	63.61	162.84	
Psychotherapy Total:						428363.08
Psychotherapy	Hour	131	33.36	98.02	428363.08	
Specialized Medical Equipment and Supplies Total:						10719.56
Specialized Medical Equipment and Supplies	Year	24	3.96	112.79	10719.56	
GRAND TOTAL:						8921588.67
Total Estimated Unduplicated Participants:						1948
Factor D (Divide total by number of participants):						4579.87
Average Length of Stay on the Waiver:						311

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
Enhanced Case Management Total:						4431987.17
Enhanced Case Management	Month	1230	9.92	363.23	4431987.17	
Homemaker Total:						2832455.37
Homemaker	15 Minutes	302	1326.59	7.07	2832455.37	
Skilled Nursing, Licensed Vocational Nurse Total:						4872.04
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	5	69.75	13.97	4872.04	
Skilled Nursing, Registered Nurse Total:						6114.76
Skilled Nursing, Registered Nurse	15 Minutes	4	79.33	19.27	6114.76	
Attendant Care Total:						508577.92
Attendant Care	15 Minutes	55	971.31	9.52	508577.92	
Home-Delivered Meals / Nutritional Supplements Total:						618690.73
Home-Delivered Meals / Nutritional Supplements	Month	865	14.03	50.98	618690.73	
Medi-Cal Supplements for Infants and Children in Foster Care Total:						4056.00
Medi-Cal Supplements for Infants and Children in Foster Care	Month	1	12.00	338.00	4056.00	
Minor Physical Adaptations to the Home Total:						143.89
Minor Physical Adaptations to the Home	Year	4	0.41	87.74	143.89	
Non-Medical Transportation Total:						419814.00
Non-Medical					419814.00	

GRAND TOTAL:	9282753.75
Total Estimated Unduplicated Participants:	1948
Factor D (Divide total by number of participants):	4765.27
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation	Month	498	8.43	100.00		
Nutritional Counseling Total:						162.84
Nutritional Counseling	Hour	1	2.56	63.61	162.84	
Psychotherapy Total:						444712.82
Psychotherapy	Hour	136	33.36	98.02	444712.82	
Specialized Medical Equipment and Supplies Total:						11166.21
Specialized Medical Equipment and Supplies	Year	25	3.96	112.79	11166.21	
GRAND TOTAL:						9282753.75
Total Estimated Unduplicated Participants:						1948
Factor D (Divide total by number of participants):						4765.27
Average Length of Stay on the Waiver:						311

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
Enhanced Case Management Total:						4608546.01
Enhanced Case Management	Month	1279	9.92	363.23	4608546.01	
Homemaker Total:						2945003.27
Homemaker	15 Minutes	314	1326.59	7.07	2945003.27	
Skilled Nursing, Licensed Vocational Nurse Total:						4872.04
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	5	69.75	13.97	4872.04	
Skilled Nursing, Registered Nurse Total:						6114.76
Skilled Nursing, Registered Nurse					6114.76	
GRAND TOTAL:						9661561.15
Total Estimated Unduplicated Participants:						1948
Factor D (Divide total by number of participants):						4959.73
Average Length of Stay on the Waiver:						311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minutes	4	79.33	19.27		
Attendant Care Total:						**536318.53**
Attendant Care	15 Minutes	58	971.31	9.52	**536318.53**	
Home-Delivered Meals / Nutritional Supplements Total:						**643724.46**
Home-Delivered Meals / Nutritional Supplements	Month	900	14.03	50.98	**643724.46**	
Medi-Cal Supplements for Infants and Children in Foster Care Total:						**4056.00**
Medi-Cal Supplements for Infants and Children in Foster Care	Month	1	12.00	338.00	**4056.00**	
Minor Physical Adaptations to the Home Total:						**143.89**
Minor Physical Adaptations to the Home	Year	4	0.41	87.74	**143.89**	
Non-Medical Transportation Total:						**436674.00**
Non-Medical Transportation	Month	518	8.43	100.00	**436674.00**	
Nutritional Counseling Total:						**162.84**
Nutritional Counseling	Hour	1	2.56	63.61	**162.84**	
Psychotherapy Total:						**464332.50**
Psychotherapy	Hour	142	33.36	98.02	**464332.50**	
Specialized Medical Equipment and Supplies Total:						**11612.86**
Specialized Medical Equipment and Supplies	Year	26	3.96	112.79	**11612.86**	
GRAND TOTAL:						**9661561.15**
Total Estimated Unduplicated Participants:						**1948**
Factor D (Divide total by number of participants):						**4959.73**
Average Length of Stay on the Waiver:						311

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
Enhanced Case Management Total:						4792311.33
Enhanced Case Management	Month	1330	9.92	363.23	4792311.33	
Homemaker Total:						3057551.16
Homemaker	15 Minutes	326	1326.59	7.07	3057551.16	
Skilled Nursing, Licensed Vocational Nurse Total:						4872.04
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	5	69.75	13.97	4872.04	
Skilled Nursing, Registered Nurse Total:						6114.76
Skilled Nursing, Registered Nurse	15 Minutes	4	79.33	19.27	6114.76	
Attendant Care Total:						554812.27
Attendant Care	15 Minutes	60	971.31	9.52	554812.27	
Home-Delivered Meals / Nutritional Supplements Total:						669473.44
Home-Delivered Meals / Nutritional Supplements	Month	936	14.03	50.98	669473.44	
Medi-Cal Supplements for Infants and Children in Foster Care Total:						4056.00
Medi-Cal Supplements for Infants and Children in Foster Care	Month	1	12.00	338.00	4056.00	
Minor Physical Adaptations to the Home Total:						143.89
Minor Physical Adaptations to the Home	Year	4	0.41	87.74	143.89	
Non-Medical Transportation Total:						453534.00
Non-Medical Transportation	Month	538	8.43	100.00	453534.00	
Nutritional Counseling Total:						162.84
Nutritional Counseling	Hour	1	2.56	63.61	162.84	
Psychotherapy Total:						483952.19
Psychotherapy	Hour	148	33.36	98.02	483952.19	
Specialized Medical						12059.51

GRAND TOTAL:	10039043.42
Total Estimated Unduplicated Participants:	1948
Factor D (Divide total by number of participants):	5153.51
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Equipment and Supplies Total:						
Specialized Medical Equipment and Supplies	*Year*	*27*	*3.96*	*112.79*	***12059.51***	
				GRAND TOTAL:		***10039043.42***
				Total Estimated Unduplicated Participants:		***1948***
				Factor D (Divide total by number of participants):		***5153.51***
				Average Length of Stay on the Waiver:		*311*