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:
Multipurpose Senior Services Program

C. Waiver Number:CA.0141
Original Base Waiver Number: CA.0141.

D. Amendment Number:CA.0141.R06.12

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

11/12/23

Approved Effective Date: 11/12/23
Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

The purpose of the amendment is to include telehealth as a permanent service delivery option for specified waiver services, in compliance with California Welfare and Institutions Code section 14132.725; federal statute and regulations; and as agreed upon by the applicant, participant, legal representative, and Medi-Cal provider.
The amendment also revises the implementation date for the changes previously approved in the amendment CA.0141.R06.10:
• The implementation date for the new waiver service unit types will be changed from July 1, 2023 to December 31, 2023 in the Attachment #1: Transition Plan.
• The implementation date for the two waiver service categories for Community Transition Services (Moving and Housing/Utility Set-up) to be combined into one Waiver Service category (Community Transition Services: Combined) will be changed from July 1, 2023 to December 31, 2023 in Appendix C.
• Waiver Year Five estimates in Appendix J will be updated to reflect use of the new waiver service unit types for half of the year instead of the full year.

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**	
☐ **Appendix B Participant Access and Eligibility**	
☒ **Appendix C Participant Services**	Community Transition Services
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I Financial Accountability**	
☒ **Appendix J Cost-Neutrality Demonstration**	J-2: WY 5 Estimates

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. Revising the implementation date for the changes previously approved in the amendment CA.0141.R06.10.

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*):

Multipurpose Senior Services Program

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.0141
Waiver Number:CA.0141.R06.12
Draft ID: CA.008.06.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/19
Approved Effective Date of Waiver being Amended: 07/01/19

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:

N/A

○ **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:

(In effect until December 31, 2021. Effective January 1, 2022 all CCI MSSP sites will be carved out of the demonstration). California's Section 1115(a) Medicaid Waiver Renewal, Medi-Cal 2020 Demonstration. Inclusive of the integrated Managed Long-Term Services and Supports (MLTSS) is the Multipurpose Senior Services Program 1915(c) Home and Community-Based Waiver (MSSP).

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 objective of the Multipurpose Senior Services Program (MSSP) is to avoid premature placement of persons in nursing facilities, while fostering independent living in the community. MSSP provides services to eligible persons enabling them to remain in or return to their homes. MSSP also assures the health and safety of Waiver Participants in the community setting. Services must be provided at a cost lower than that for nursing home placement.

Section 1915(c) of Title XXI of the Social Security Act permits states to request waivers of federal law in order to provide certain services to persons at home or in the community as a cost-neutral alternative to institutionalized health care. CMS approves and oversees these agreements, granting the waivers to each state's designated Medicaid (Medi-Cal in California) agency. In California, this designated State agency is the Department of Health Care Services (DHCS).

The MSSP Waiver (one of several waivers administered by DHCS) is implemented by the California Department of Aging (CDA) under the supervision of DHCS through an Interagency Agreement (IA). DHCS monitors overall technical/programmatic compliance and administrative oversight serving as the central point of contact for CMS.

Within CDA, the MSSP Bureau is the unit responsible for oversight and monitoring the local sites' compliance with their program and contract requirements. The MSSP Bureau oversees programmatic, fiscal, and service elements of local site operation through policy directives, technical assistance, complaint investigation, and conducting formal program Utilization Reviews (UR). The CDA Audits and Risk Management Branch conducts fiscal audits of local sites at least every three years.

Following State contracting requirements, CDA contracts with local government and private nonprofit agencies to administer the program locally. These local sites represent a wide variety of service delivery agencies and geographic areas with diversified Waiver Participants population. Each site is an administratively separate entity within its host
agency. Other than the direct provision of care management services, MSSP sites' staff purchase the Waiver Services through written agreements with local vendors.

Care Management is the cornerstone of MSSP. It involves the coordination and usage of existing community resources enabling Waiver Participants to continue living at home. MSSP care management includes: assessment, care planning, service arrangement, Waiver Participant monitoring and purchased Waiver Services. A team of health and social service professionals provides each Waiver Participant with a complete health and psychosocial assessment to determine the services needed. The team then works with the Waiver Participant and family to develop an individualized care plan. To arrange for services, site care management staff first explore informal support that might be available through family, friends and the voluntary community. Staff then review existing publicly funded services and make direct referrals whenever possible. If needed services are not available through friends, family and other programs, the care management team can authorize the purchase of Waiver Services from program funds.

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:

Multipurpose Senior Services Program Sites

Site #	County
01	Alameda
04	Los Angeles #1
05	Los Angeles #2
06	San Francisco
07	San Diego
08	Lake, Mendocino
09	Humboldt
10	Butte, Glenn, Tehama
11	Sonoma
14	Stanislaus
16	Los Angeles #3
17	San Bernardino
20	Santa Clara
21	Fresno, Madera
23	Imperial
24	Riverside
25	Lassen, Modoc, Shasta, Siskiyou, Trinity
26	Marin
28	Merced
32	Amador, Calaveras, Mariposa, Tuolumne
33	Kings, Tulare
34	Ventura
37	Alameda
39	Los Angeles #4
40	Los Angeles #5
41	Orange
43	Los Angeles #6
47	Contra Costa
48	Santa Cruz
49	San Joaquin
51	Kern
52	Monterey
53	Placer, Sacramento, Yolo
54	Santa Barbara
55	Yuba, Sutter
56	Napa, Solano
57	El Dorado

Participants may exercise their freedom of choice by selecting any MSSP site from which to receive services.

☐ **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:

The California Department of Aging (CDA) operates the Multipurpose Senior Services Program (MSSP) and is responsible for the development of the MSSP 1915(c) Home and Community-Based Services (HCBS) Waiver application. CDA maintains continuous communication on MSSP program operations with the local MSSP sites though CDA's oversight activities including Waiver Participant satisfaction surveys and periodic meetings between CDA and the MSSP Site Association (MSA). This ongoing input and technical assistance keeps MSSP policies and procedures current. MSSP sites in turn maintain continuous communication with MSSP Participants. Participant input is provided on an ongoing basis through the care planning and management process (at least monthly) and through Waiver Participant satisfaction surveys. CDA operates the MSSP Waiver via an Interagency Agreement on behalf of the Department of Health Care Services (DHCS), which is the Medicaid Single State Agency.

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 the 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 external 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. Major themes of the feedback and DHCS response are summarized below:

DHCS received a total of 30 comments from 15 entities regarding the telehealth, five (5) of which pertain to the MSSP Waiver. Major themes of the five (5) comments and CDA/DHCS response are summarized below:

- All five comments were from MSSP site providers.
- Three out of five comments expressed support for the permanent addition of telehealth to the Waiver.
- Two out of five comments contained questions for operationalizing telehealth, beyond the scope of the amendment.

CDA/DHCS' response included CDA's plan to create and implement a Telehealth Checklist and revise the MSSP Site Manual to provide specific guidance to the MSSP sites.

- One out of five comments requested clarification language related to the conditions/requirements that telehealth is allowable. CDA/DHCS' response included clarification of the listed requirements.

There were no changes made to the MSSP Waiver application as a result of the public input.

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, 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) 440-5720

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: Kraw

First Name: Amber

Title: Health Program Specialist, Division of Home and Community Living, MSSP

Agency: California Department of Aging

Address: 2880 Gateway Oaks Dr., Suite 200

Address 2:

City: Sacramento

State: **California**

Zip: 95833

Phone: (916) 419-7575 **Ext:** ☐ **TTY**

Fax: (916) 928-2508

E-mail: Amber.Kraw@aging.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:

The combining of the previously approved Community Transition Services will not result in any changes in the amount of services that are provided, a decrease in rates, or how the services are delivered to participants. The MSSP site will only be making minor adjustments in how these services are billed to the fiscal intermediary, California Medicaid Management Information System (CA-MMIS). For both Housing/Utility Set Up and Moving Services, sites will only be adjusting the unit type name from “event” to “service” and the code under which the services are billed. Maximum rate thresholds will remain the same.

On March 30, 2022 CDA offered a Code Conversion Overview Webinar to all MSSP sites to review all changes to the MSSP billing codes for services included in this amendment. During the webinar, questions were answered and comments were accepted. DHCS and CDA also reached out for public input/comment for the period of July 1 – 30, 2022.

To ready themselves for the changes, MSSP sites have been instructed to begin implementing system changes to their individual care management systems to add the new Healthcare Common Procedure Coding System (HCPCS) billing codes and units of service types. Prior to the beginning of a new Fiscal Year (FY), each site completes the budget, contract renewal and rate threshold review process, before being able to bill for services for that FY. The timetable for transitioning providers to the new units of services/new combined Community Transition Service has been incorporated into the approximate timetable of this process:

February/March 2023
1. CDA receives budgets from MSSP sites for the upcoming FY.
2. Contract revision process involving the CDA MSSP Team, CDA Office of Legal Services, CDA Audits and Risk Management Branch, and CDA Business Management Branch (BMB).
3. BMB drafts STD 215s and submits to DHCS Accounting for signature.

April/May 2023
1. Once STD 215s are signed and returned from DHCS, contract packages are sent out to MSSP sites by BMB for signature.
2. MSSP sites renegotiate Waiver Service vendor/provider contracts, considering any changes to service unit types.
3. MSSP sites review maximum rate thresholds for each Waiver Service HCPCS code/Unit Type, then submit updates to CDA for review and approval.
4. CDA calculates Care Management (CM) & Care Management Support (CMS) rates based on the approved budget amounts.
5. Rate input documents containing any rate threshold updates are submitted by CDA to the fiscal intermediary, CA-MMIS, for system updates.

June/July/August 2023
1. Signed contracts are received back from MSSP sites (Note: The timeframe can vary greatly depending on when the signed documents are received back from the sites. Many sites must await board resolutions prior to signing). BMB executes site contracts and provides MSSP with the STD 213s and entire contract package.
2. MSSP submits STD 213s and grant allocation memos to DHCS for funding upload into CA-MMIS. Once funding is uploaded into CA-MMIS, sites may begin billing for service provided. Note: Upload process can take up to 6 weeks by CA-MMIS.
3. MSSP sites have been instructed to cease billing previous local codes for service dates after 12/30/23. CA-MMIS has completed system changes to reflect an end date of 12/30/23 to all previously used local billing codes. Any billing of local codes for services after 12/30/23 will be denied. New HCPCS codes are active in the system as of 12/31/23.

As with each new FY, CDA will work closely with each MSSP site throughout the entire process, providing individual technical assistance on an as-needed basis. Participants will not see a change to any services provided.

While CMS approved an implementation date of July 1, 2023, ultimately implementation will be delayed until December 31, 2023 to allow additional time for provider training, bulletin updates, and system testing to facilitate the smoothest transition possible.

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.

California 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):

WAIVER OF COMMUNITY INCOME AND RESOURCE POLICIES FOR THE MEDICALLY NEEDY (§ § 1915(c)(3) and 1902 (a)(10)(C)(i)(III) of the Social Security Act).

A. A waiver of § 1902 (a)(10)(C)(i)(III) of the Social Security Act is requested for the medically needy, only as reflected in section C below.

B. Computation of income for purposes of FFP limits is not applicable (N/A).

C. The following is a description of the income and resource methods and standards that differ from those otherwise required for the medically needy under the State Plan (including approved § 1902 (r)(2) policies) and § 1902 (a)(10)(C)(i)(III) for individuals living in the community.

SECOND VEHICLE EXEMPTION FOR WAIVER PROGRAM: a recipient may claim an exemption for a second, modified vehicle if it was modified to accommodate the physical handicap(s) for the medical needs of the individual. Verification shall be by physician's written statement of necessity.

>>>>>>>>
>>>>>

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 the waiver participant's needs cannot be met via telehealth services because physical, in-person assistance is required to support the waiver participant's health and safety, then telehealth services shall not be an option and in-person service delivery will be the method of service delivery.
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 under Final Regulation CMS-2249-F/CMS-2296-F. 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 was 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. 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. The goal of using technology is not to replace human assistance, but to increase access to care and maximize the use of technology to support people where appropriate.
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. Family members may also be eligible for training, as appropriate, to support the provision of services if determined to be beneficial for the participant.
10. The following services can be provided via Telehealth, in alignment with the above requirements:
- Care Management
- Consultative Clinical Services
- Money Management

- Social Support
- Therapeutic 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 Aging (CDA), Multipurpose Senior Services Program Bureau

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 provides administrative oversight functions in accordance with Waiver requirements to the California Department of Aging (CDA) through an Interagency Agreement (IA). The IA addresses that DHCS shall review all CDA Waiver-related policies, procedures, fiscal and administrative oversight, rules/regulations for consistency with the Waiver, Medicaid statutes and regulations.

DHCS is responsible for monitoring and oversight of CDA, the agency operating the MSSP Waiver. Through discovery, remediation, and system improvement activities, DHCS monitors the operating agencies performance and its assigned Waiver operational and administrative functions in accordance with Waiver requirements. DHCS also monitors the existence of continuous quality improvement, appropriate access to services, the provision of services as specified in the Waiver, and health and welfare of Waiver participants.

DHCS reviews the CDA Utilization Review Reports, site Corrective Action Plans and data reports to ensure compliance with state and federal regulations, Medicaid statute, the interagency agreement between CDA and DHCS, and Waiver requirements. DHCS review of CDA Utilization Review Reports occurs on an ongoing basis. CDA completes its review of each MSSP site every two years and submits the Utilization Review Reports to DHCS upon completion of each site visit. If DHCS identifies issues or trends during its review of CDA's Utilization Review Reports, site Corrective Action Plans and data reports, DHCS will conduct on-site Independent Reviews to remediate issues and provide technical assistance to CDA. DHCS maintains authority to conduct independent on-site visits to address deficiencies and to train/educate the MSSP sites as appropriate. Additionally, the DHCS compliance team may accompany the CDA team during Utilization Reviews, as needed, to ensure all programmatic and Waiver requirements are being met. DHCS and CDA hold regular monthly calls to discuss Utilization Reviews, Corrective Action Plans, Remediation, site visit schedules, and identified needs for technical assistance.

Using a Monitoring and Oversight Protocol, DHCS monitors compliance with the following assurances:
- Level of Care,
- Service Plan,
- Qualified Providers,
- Participant Health and Welfare,
- Administrative Authority, and
- Financial Accountability.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

Following State contracting requirements, CDA contracts with local government agencies to administer the program locally. These local sites represent a wide variety of service delivery agencies and geographic areas with diverse Waiver Participant populations. Each site is an administratively separate entity within its host agency. Other than the direct provision of care management services, MSSP site staff purchase the Waiver Services through written agreements with local vendors.

☒ **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:

Following State contracting requirements, CDA contracts with local private non-profit agencies to administer the program locally. These local sites represent a wide variety of service delivery agencies and geographic areas with diverse Waiver Participant populations. Each site is an administratively separate entity within its host agency. Other than the direct provision of care management services, MSSP site staff purchase the Waiver Services through written agreements with local vendors.

Care Management involves the coordination and usage of existing community resources which provide the services required, enabling Waiver Participants to continue living at home. MSSP care management provides for Waiver Participant assessment, care planning, service arrangement and Waiver Participant monitoring. A team of health and social service professionals provides each Waiver Participant with a complete health and psychosocial assessment to determine the service(s) needed. The care management team then works with the Waiver Participant, family and/or care givers to develop an individualized care plan. To arrange for services, site care management staff first explore informal support that might be available through family, friends and the voluntary community. Staff then review existing publicly funded services and make direct referrals whenever possible. If needed services are not available through friends, family and other programs, the care management team can authorize the purchase of Waiver Services with program funds.

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 Aging, Long-Term Care and Aging Services Division, Multipurpose Senior Services Program Bureau

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:

Multipurpose Senior Services Program (MSSP) site performance is monitored as part of the California Department of Aging's (CDA) Utilization Review (UR) process. Each MSSP site is reviewed at least every 24 months by a CDA team that includes a nurse evaluator and program analyst. If either discipline is not present at the site review, they are accessible by phone. The team reviews Waiver Participant records, progress notes, assessments, re-assessments, screening documents, timeliness of action, Waiver Participant plans of care, documentation of the audit trail, the verification of service delivery, Waiver Participant satisfaction and any other pertinent documentation. Noncompliance with Waiver and program standards can result in a plan of correction, technical assistance and financial sanctions. When corrective action is required, the MSSP site responds with a formal Corrective Action Plan (CAP) to cover any deficiencies. Upon receipt of the CAP, CDA monitors the site's resolution process to ensure complete remediation of the deficiency. Once the CAP is reviewed by the CDA UR team, the site is given an opportunity to implement the developed strategy. Once adequate time for implementation has occurred, CDA often conducts a Follow-up Visit with the site to evaluate the effectiveness of the site's new practice, and/or requests submission of records for additional review by CDA. The site does not receive a CAP approval letter until complete resolution has been verified by CDA. Technical assistance is provided throughout the process on an as needed basis.

New MSSP sites receive up to four onsite visits within the first year and a baseline UR at twelve months.

CDA also provides ongoing technical assistance to MSSP sites and requires quarterly reports from each site on MSSP program performance that includes updates on enrollment levels, fiscal performance and quality assurance activities. To maintain communication with MSSP sites, CDA communicates regularly via telephone and email with each MSSP site and meets regularly throughout the year with the MSSP Site Association (MSA).

The Medicaid agency, DHCS, reviews the following on an ongoing basis:
- CDA Utilization Review (UR) Reports, continuously and ongoing
- Site Corrective Action Plans (CAPs), continuously and ongoing
- Data compliance reports, quarterly
- MSSP Quarterly Reports

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	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☒
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☒	☒
Execution of Medicaid provider agreements	☒	☒	☐
Establishment of a statewide rate methodology	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
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:
Dates & topics of Medicaid oversight meetings with CDA. Numerator: Quarterly Meetings scheduled and attended by both DHCS and CDA. Denominator: Four quarters.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Agendas and meeting minutes

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:

Medicaid review of utilization review reports generated by CDA. Numerator: Number of UR reports reviewed by DHCS. Denominator: Number of UR reports generated by CDA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CDA provides copies of all utilization review 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:

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of record reviews conducted by DHCS on targeted sites based on CDA's Utilization Review report outcomes and trends identified by DHCS. Numerator: Number of record reviews conducted by DHCS on targeted sites based on CDA's Utilization Review report outcomes and trends identified by DHCS. Denominator: Number of CDA URs which generated a Corrective Action Report.

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: DHCS reserves the right to conduct on-site visits as necessary. If DHCS identifies any issues in the CDA utilization reports, DHCS will conduct independent site visit/s to review participant records.
	☒ **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: 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.

DHCS holds two separate monthly meetings with CDA to fulfill oversight requirements. DHCS has established a monthly meeting for the specific purpose to review and discuss findings from the Utilization Review reports. Concerns resulting from CDA's findings are discussed and appropriate next steps are identified. In addition, ongoing Waiver compliance strategies are discussed to ensure both DHCS and CDA are on the same page when conducting monitoring and oversight activities. These meetings also provide the forum for discussion of Waiver performance measure results and necessary quality improvement efforts.

Additionally, DHCS and CDA hold a monthly meeting to review MSSP Waiver policy and operational activities/issues.

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.

If issues are identified during DHCS' review of CDA Utilization Reports, site Corrective Action Plans, and data reports, DHCS will issue a Corrective Action Report (CAR), which includes specific findings and recommendations for corrective action. CDA has sixty days to respond to DHCS's CAR. DHCS reserves the right to conduct on-site Independent Reviews when necessary. If a Waiver Participant has concerns regarding services, they have the right to a State Fair Hearing.

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**	65		☒
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**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:

N/A

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.

MSSP's total annual funding, as established through the annual state budget process is $49,721,605 for WY1–WY2. Effective January 1, 2022, funding increased to $56,404,036 for WY3, and $63,950,640 for WY4–WY5 to allow for an increase in participant slots and to make the rate increase for care management and care management support permanent. This equates to $5,356 per MSSP Waiver Participant slot annually. For FY1-WY2, MSSP utilized 9,283 Waiver Participant slots to serve the 11,370 potential Waiver Participants statewide on an annual basis. For WY3, Waiver Participant slots increased to 10,531 to serve the 11,940 potential Waiver Participants statewide on an annual basis. For WY4-WY5, Waiver Participant slots increased to 11,940 to serve the 13,373 potential Waiver Participants statewide on an annual basis (The difference between the two numbers represents Waiver Participant turnover during the year). Sites are not to enroll applicants whose cost would exceed the budgeted amount on an ongoing basis.

In the course of conducting Utilization Reviews, there are no findings to support that the specified limit is insufficient to assure the health and safety of participants.

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

◉ **The following dollar amount:**

Specify dollar amount: 5356

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 the applicant is screened. During the screening process, if ongoing costs are projected to exceed the cost of institutional care, the applicant is ineligible for enrollment in MSSP. However, if there is a plan to reduce costs down to the cost limit within three months, the applicant may be enrolled.

When an applicant is denied enrollment into the Waiver, the MSSP site will notify the applicant, by mail and within 10 calendar days, of the decision. The notification (Notice of Action) includes instructions advising the denied applicant and/or authorized representative how and where to request a State Fair Hearing before an Administrative Law Judge.

The MSSP care manager provides coordination of state plan benefits (those in D prime) and other community services to assure the health and safety of each MSSP Waiver Participant. The MSSP Waiver is considered a support waiver as the bulk of services come through the state plan.

If the Waiver Participant's needs exceed the scope of the MSSP Waiver, the Waiver Participant is referred to a HCBS Waiver or facility that accommodates the Waiver Participant's higher level of care.

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	11370
Year 2	11370
Year 3	11940
Year 4	13373
Year 5	13373

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	9283
Year 2	9283

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 3	11940
Year 4	11940
Year 5	11940

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:

The California Legislature allocates funding for MSSP during the annual state budget process. The funding and associated Waiver Participant slots were initially allocated based on demographic studies.

Current capacity allocation is fair with equitable accessibility for each participant from each MSSP site to MSSP site.

CDA conducted an assessment of the need for MSSP services in the general population that created a baseline for appraising the allocation of existing MSSP participant services and supported appropriate allocation of new or additional resources.

The assessment of need for MSSP is based on identifying how many individuals in the community who are not now being served would potentially meet program eligibility criteria. The allocation of waiver capacity is made to the MSSP Site serving the specific catchment area. This determination is a two-step process:

1. A frailty factor is determined as the percentage of aged 65+ Medi-Cal recipients who have had a SNF stay in the past year. This factor is then applied to aged SSI recipients to calculate the Unmet Need. Data is obtained by year from the Department of Health Care Services. This statewide frailty factor has remained generally stable over time, with some variations by county due to demographic differences or data collection methodology.

2. The next step is to identify SSI recipients (blind and disabled), age 65+. Data is obtained from the Department of Social Services.

The formula is applied on a county-by-county basis, annually, to identify the percentage of need. Counties with a higher percentage of need can be allocated additional slots as needed.

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

Local MSSP sites screen potential Waiver Participants to determine eligibility and appropriateness for participation in MSSP. Potential Waiver Participants must be: certifiable for placement in a nursing facility; age 65 or older; eligible for Medicaid; able to be served within MSSP's cost limitations; and, appropriate for care management services.

MSSP Waiver capacity is limited to the maximum number of funded slots. Enrollment of applicants into the MSSP Waiver is based on “imminent need” for services, which is determined through a standardized process to ensure fair and equitable access to the MSSP Waiver. Enrollment of applicants may not be deferred when unused waiver capacity exists. The wait list policy includes methodologies for assigning priority for enrollment based on the applicant's identified needs and high risk for poor outcomes. The statewide wait list policy also requires that the MSSP Sites manage the wait list by reviewing the eligibility and identified needs of the applicants and adjusts priority for enrollment based on changes in the applicant’s identified risk levels.

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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [x] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **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 anyone who would otherwise be eligible for SSI/SSP as provided in the Social Security Act, Section 1902(a)(10)(A)(ii)(I), including those who are eligible under section 1634(a) and (d).

All other mandatory and optional groups under the Medi-Cal State Plan, who are eligible in alignment with the following federal statute and regulations: 1902(a)(10)(A)(ii)(XXII); 1915(i); 1902(a)(10)(A)(ii)(I) and (IV); 1902(a)(10)(C); 1902(a)(10)(A)(ii)(X), and 1902(m)(1); 1902(a)(10)(A)(i)(I); 1931(b) and (d); 408(a)(11)(A); 1902(a)(52); 1902(e)(1)(B); 1925; 1931(c)(2); 1902(a)(10)(A)(i)(I); 1902(a)(10)(A)(i)(IX); 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); 1931(b) and (d); 1931(c)(1); 1634(c); 1902(a)(10)(A)(ii)(XIII) 1619(b); 1902(a)(10)(A)(i)(II)(bb); 1905(q); 1902(a)(10)(A)(i)(IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV); 1931(b) and (d); 1902(a)(10)(A)(ii)(XII); 1902(z); 1902(a)(10)(E)(ii); 1905(p)(3)(A)(i); 1905(s) 1902(a)(10)(E)(iii); 1905(p)(3)(A)(ii); 1902(a)(10)(E)(iv); 1905(p)(3)(A)(ii); 1902(a)(10)(A)(ii)(XXI); 1902(a)(10)(A)(i)(VIII); 1905z(3); 42 CFR 435.322; 42 CFR 435.320, 322 & 324; 42 CFR 435.115; 42 CFR 435.324; 42 CFR 435.215; 42 CFR 435.320; 43 CFR 435.322 & 324

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

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

  Select one and complete Appendix B-5.

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

    Check each that applies:

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

      Select one:

      - ○ **300% of the SSI Federal Benefit Rate (FBR)**
      - ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

        Specify percentage: [ ]
      - ○ **A dollar amount which is lower than 300%.**

        Specify dollar amount: [ ]
    - ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
    - ☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
    - ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
    - ☐ **Aged and disabled individuals who have income at:**

      Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

income:

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

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

- ◉ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

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

  Specify:

- ○ **Other**

  Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

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

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

◉ **Other**

Specify:

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

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

The operating agency, the California Department of Aging (CDA), contracts with local government and private nonprofit agencies [MSSP sites] to administer the MSSP. Qualified site staff (Nurse Care Managers who are Registered Nurses [RN]) employed by the MSSP sites are responsible for LOC evaluations/re-evaluations. CDA visits each MSSP site every other year to perform Utilization Reviews to ensure the applicable LOC has been properly applied. DHCS reviews the CDA Utilization Review Reports, site Corrective Action Plans and data reports, to ensure compliance with State and federal regulations, Medicaid statute, the interagency agreement between CDA and DHCS, and Waiver requirements, on an ongoing flow basis.

○ **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:

The MSSP site staff performing level of care evaluations are Nurse Care Managers who are Registered Nurses (RN) licensed by the State of California who at least have one year experience.

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.

A MSSP applicant must be certified as functionally impaired or have a medical condition to the extent of requiring the level of care (LOC) provided in a nursing facility. The LOC determination must be made by the MSSP Nurse Care Manager on an MSSP approved form, consistent with the need for institutionalization per the California Code of Regulations, Title 22, Sections 51334 and 51335. The assessment of functional impairment includes cognition, Instrumental Activities of Daily Living (IADL), Activities of Daily Living (ADL) and environment. The instrument used is the MSSP Level of Care Certification Form.

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.

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:

A LOC determination is completed for each MSSP Waiver Participant upon entry into the program. The LOC determination validates that the Waiver Participant meets nursing facility level of care. Both the evaluation/reevaluation are made by the Nurse Care Manager (NCM) at the local MSSP site using the State prescribed criteria and certification form. The LOC determination is based upon the professional evaluation of the Waiver Participant's medical and functional conditions. The supporting evidence is summarized on the certification form which is signed and dated by the NCM. The evaluation/reevaluation includes the following components:

1. Evaluation of health condition
2. Evaluation of cognitive and functional ability
3. Evaluation of environmental accessibility/adaptation needs
4. Identification of individual health care needs
5. Identification of services needed and formulation of plan of care
6. Coordination of plan of care by the NCM and the Social Work Care Manager (SWCM)

Enrolled Participants have reevaluations which are performed by a NCM no later than 365 days from the last LOC, or more often where there is a change of condition.

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):*

Reevaluations of the Waiver Participant's LOC are conducted at a minimum every 365 days. MSSP sites have various methods to ensure timely LOC re-evaluations, such as: Excel spreadsheets that calculate all LOCs due in the next month, care management system tickler files, and care management team meetings to validate this information.

Utilization reviews (UR) are conducted by the California Department of Aging (CDA). CDA reviews LOCs for timeliness, as well as the proactive methods the site has established to ensure effectiveness. The UR team analyzes case records, progress notes, assessment/reassessments, the Waiver Participant's plan of care, individual service plans, and any other documentation pertinent to determining that:

1. Documentation supports that Level of Care (LOC) criteria have been met,
2. Evaluations and reevaluations are timely,
3. Documentation has been completed by the appropriate MSSP site personnel.

If deficiencies in LOC reevaluations are identified, CDA works with the site through Technical Assistance (TA) and the written report of the findings and recommendations that is issued to the site by CDA will include a formal written request for a Corrective Action Plan (CAP) specific to remediating the deficiencies. The site is required to respond to CDA within 30 days of the date of the UR report and develop a formal CAP to address any deficiencies identified. Upon receipt of the CAP, CDA monitors the site's resolution process to ensure complete remediation of the deficiency. Once the CAP is reviewed by the CDA UR team, the site is given an opportunity to implement the developed strategy. Once adequate time for implementation has occurred, CDA often conducts a Follow-up Visit with the site to evaluate the effectiveness of the site's new practice, and/or requests submission of records for additional review by CDA. The site does not receive a CAP approval letter until complete resolution has been verified by CDA. TA is provided throughout the CAP process on an as needed basis.

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:

MSSP Waiver Participant records are maintained at each site. All sites have a contractual obligation for the maintenance and storage of all information collected on each of their Waiver Participants. These records are maintained at each site for a minimum of seven years from the Waiver Participant's termination date. Waiver Participant records will be secured in locked files and care management data systems will have appropriate confidentiality safeguards. Responsibility for ensuring that these requirements are met rests with the individual site program administrator. CDA is responsible for setting standards for record maintenance and security.

The names of persons receiving MSSP services are confidential and protected from unauthorized disclosure in accordance with: The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191; Title 45, CFR, Section 205.50; California Welfare and Institutions Code, Section 10850; and the California Information Practices Act of 1977. All participant-related information, records, and data elements shall be protected by all MSSP contractors from unauthorized disclosure.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percent of all Waiver Participants who had an initial level of care done at enrollment out of total cases reviewed. Numerator: Number of Waiver Participants who had an initial level of care done at enrollment. Denominator: Total number of cases reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 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:
Initial LOC determinations completed within 30 days of application out of total number of cases reviewed. Numerator: Number of initial LOC determinations completed within 30 days of application. Denominator: Total number of cases reviewed.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Percent of level of care (LOC) determinations completed on an approved LOC form out of total number of case records reviewed. Numerator: Number of LOC determinations completed on an approved LOC form. Denominator: Total number of cases reviewed.

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of LOC determinations completed by the MSSP site Nurse Care Managers out of total number of cases reviewed. Numerator: Number of LOC determinations completed by the MSSP site Nurse Care Manager. Denominator: Total number of cases reviewed.

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

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

Data Aggregation and Analysis:

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

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

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.

If deficiencies in LOC determination are identified, the written report of the findings and recommendations that is issued to the site from CDA will include a formal written request for a corrective action plan (CAP) specific to remediating the deficiencies. The site is required to respond to CDA within 30 days of the date of the Utilization Review report and develop a formal CAP to address any deficiencies identified. Upon receipt of the CAP, CDA monitors the site's resolution process to ensure complete remediation of the deficiency. Once the CAP is reviewed by the CDA UR team, the site is given an opportunity to implement the developed strategy. Once adequate time for implementation has occurred, CDA often conducts a Follow-up Visit to evaluate the effectiveness of the site's new practice, and/or requests submission of records for additional review by CDA. The site does not receive a CAP approval letter until complete resolution has been verified by CDA. Technical assistance is provided throughout the process on an as needed basis. Annual analysis of this data on an aggregate basis enables the State to determine the benchmark and need for regional and statewide training.

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).

An individual determined to be eligible for MSSP is provided an explanation of Waiver services, limitations, and requirements, and any available alternative programs. The individual is given the choice between the MSSP and other care/institutionalization options and between Waiver services and providers. This information is provided in writing on the MSSP Application and is explained by the care manager during a face-to-face visit. The Participant acknowledges that they were given the above choices by signing the MSSP Application. The Participant is also provided a copy of two documents, "Participant Rights in MSSP" and "Your Rights Under California Public Benefits Programs".

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 MSSP sites have a contractual obligation to maintain and store all information collected on each of their Waiver Participants, including freedom of choice forms. These records will be maintained at each site for a minimum of seven years from the Participant termination date. Waiver Participant records will be secured in locked files and care management data systems will have appropriate confidentiality safeguards. Responsibility for ensuring that these requirements are met rests with the individual site program administrator. CDA is responsible for setting standards for record maintenance and security.

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):

MSSP sites are required to assure access to oral and written assistance to Limited English Proficient persons. MSSP sites hire bilingual staff, arrange for interpreters when necessary and translate written materials when a beneficiary requires information in a language other than English. CDA's contract with each MSSP site requires sites to have an appropriate array of service providers to allow Waiver Participant choice within their community.

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	**Care Management**		
Statutory Service	**Respite Care**		
Statutory Service	**Supplemental Homemaker Services**		
Extended State Plan Service	**Supplemental Personal Care**		
Other Service	**Adult Day Care**		
Other Service	**Assistive Technology**		
Other Service	**Communication: Device**		
Other Service	**Communication: Translation/Interpretation**		
Other Service	**Community Transition Services (Combined)**		
Other Service	**Community Transition Services: Housing & Utility Set-up**		
Other Service	**Community Transition Services: Moving Services**		
Other Service	**Consultative Clinical Services**		
Other Service	**Minor Home Repairs and Maintenance**		
Other Service	**Money Management**		
Other Service	**Non-Medical Home Equipment**		

Service Type	Service		
Other Service	Nutritional Services		
Other Service	Social Support		
Other Service	Supplemental Protective Supervision		
Other Service	Therapeutic Counseling		
Other Service	Therapeutic Services		
Other Service	Transportation		

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):

Care Management

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

MSSP Site Care Management (50)
The service MSSP care management is only provided to MSSP participants by qualified MSSP providers. All Waiver Participants have their choice of providers within the MSSP sites. The site uses a team consisting of a Social Work Care Manager (SWCM) and a Nurse Care Manager (NCM) to directly provide care management. The care management team provides the following components of care management: assessment of Waiver Participant needs; LOC certification; care plan development; service implementation, coordination and monitoring; ongoing Waiver Participant contact (including a monthly, at minimum, telephone call; quarterly face-to-face visits[including a minimum of an annual visit by the NCM]); LOC certification no later than 365 days of the last LOC; annual CM team reassessment of the Participant; and an annual care plan update (note: all previously mentioned activities can occur more frequently should the Waiver Participant situation warrant it). The care management team can be assisted (with the team's supervision) by Care Management Aides (CMA) who perform more routine tasks such as screening and monitoring (they cannot sign off on any care management documents). The care management team has to be supervised by the local site's Supervising Care Manager (SCM).

This service assists Waiver Participants in gaining access to needed Waiver and other state plan services, as well as needed medical, social, and other services, allowing the Waiver Participant freedom of choice, regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the Waiver Participant's care plan. Additionally, care managers initiate and oversee the process of assessment and reassessment of Waiver Participant level of care and the monthly review of care plans.

The MSSP care management system vests in the local MSSP site contractor responsibility for assessing, care planning, locating, authorizing, coordinating, and monitoring a package of long-term care services and supports for Waiver Participants. The teams are responsible for care management services including: the assessment; care plan development; service authorization and delivery; monitoring and follow up components of the program. Although the primary care manager (PCM) will be either a SWCM or NCM, both professionals will be fully utilized in carrying out the various care management functions. Case records must document all Waiver Participant contact activity each month.

The unit of service for care management is a month.

Deinstitutional Care Management (DCM) (4.6)
Is used only with individuals who are institutionalized. DCM allows care management and waiver services to begin up to 180 consecutive days prior to an individual's discharge from an institution. It may be used in 2 situations, as follows:

1. The care management team goes into a nursing facility or acute hospital to facilitate a resident's discharge into the community and enrollment into the Waiver.
2. An established MSSP Waiver Participant is institutionalized and MSSP services are necessary for the person to be discharged back into the community.

In either situation, to claim FFP for this service, care management waiver services provided during this period are combined into one unit of DCM and billed upon the Waiver Participant's discharge and enrollment into the Waiver.

The unit of service for DCM is a month.

Federal Financial Participation (FFP) is not claimed for DCM services where the participant does not transition into the Waiver. No care management services available under the state plan will be duplicated under the MSSP Waiver.

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Care Manager Aide
Agency	Social Work Care Manager
Agency	Nurse Care Manager

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

Care Manager Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Two years of experience working with frail older adults or a bachelor's degree in a human services discipline.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of employment.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

Social Work Care Manager

Provider Qualifications

License *(specify):*

Bachelor's degree in social work, psychology, counseling, rehabilitation, gerontology, or sociology, or related field, plus two years of experience working with frail older adults.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Sites may request an exemption to minimum qualifications with approval required from CDA.

Exemptions to minimum care management staff qualifications are only granted for MSSP site staff. The exemption request must be submitted in writing and approved in writing by CDA prior to making a commitment to hire. The site must provide documentation of its unsuccessful recruitment effort and have a demonstrated history of compliance in all program standards. The site must submit the candidate's qualifications that document their ability to perform all duties of the position as well as documentation listing goals and time frames for accomplishing any required training and development activities. The CDA utilization reviews (UR) confirm the candidate's competency in performing all care management activities/duties. CDA has the right to rescind an exemption anytime if findings demonstrate that the exempted employee has not provided care management service in compliance with minimum program standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of employment.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

Nurse Care Manager

Provider Qualifications

License *(specify):*

California Department of Consumer Affairs Board of Registered Nursing license that is current and in good standing and one year of clinical experience.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of employment and every two years thereafter or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite 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:**

Respite Care (In-Home) (5.1)
The state plan does not provide for respite care. The purpose of respite care is to relieve the Waiver Participant's caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a Waiver Participant while the family or other individuals who normally provide fulltime care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver.

As dictated by the Waiver Participant's circumstances, services will be provided In-Home (5.1) through appropriate available resources. Individuals providing services in the Waiver Participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the Waiver Participant's care plan.

The unit of service can be 15 minutes or per diem. Any combination of direct care and protective supervision services exceeding 24 hours of care per day under this waiver regardless of the funding source will not be authorized.

Federal Financial Participation (FFP) will not be claimed for the following:
- Respite services provided beyond thirty consecutive days
- The cost of room and board when respite is provided in the participant's home or place of residence.

Respite Care (Out-of-Home) (5.2)
The state plan does not provide for respite care. The purpose of respite care is to relieve the Waiver Participant's caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a Waiver Participant while the family or other individuals who normally provide fulltime care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver.

As dictated by the Waiver Participant's circumstances, services will be provided Out-of-Home (5.2) through appropriate available resources, such as Adult Day Programs.

The unit of service can be 15 minutes or per diem. Any combination of direct care and protective supervision services exceeding 24 hours of care per day under this waiver regardless of the funding source will not be authorized.

Federal Financial Participation (FFP) will not be claimed for the following:
- Respite services provided beyond thirty consecutive days
- The cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence.

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
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of initial contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

State of California, CCR, Title 22, §§74600 et seq.

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 & Certification.

Frequency of Verification:

Prior to/at time of initial contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Homemaker

Alternate Service Title (if any):

Supplemental Homemaker Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Supplemental Homemaker Services (3.1)
This service applies to the performance of household tasks rather than to the care of the Waiver Participant. Homemaker activities are limited to: household cleaning, laundry, shopping, food preparation, and household maintenance. Waiver Participant instruction in performing household tasks and meal preparation may also be provided.

The care manager completes a health and psychosocial assessment which assess all Waiver Participant needs including the need for homemaker services and personal care. The assessments also consider IHSS services in place and whether the Waiver Participant's needs are being met.

Supplemental Homemaker Services under the MSSP Waiver are limited to additional services not otherwise covered under the state plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization.

The unit of service can be 15 minutes or per diem.

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	Home Health Agency
Agency	Private Nonprofit or Proprietary Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supplemental Homemaker Services

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

State of California, CCR, Title 22, §§74600 et seq.

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.

Frequency of Verification:

CDPH Licensing and Certification.
Prior to/at time of initial contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supplemental Homemaker Services

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Supplemental Personal 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:

Supplemental Personal Care (3.2)
Supplemental Personal Care under the MSSP Waiver is limited to additional services not otherwise covered under the state plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization. Services are provided when personal care services furnished under the approved state plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the state plan. The provider qualifications specified in the state plan apply.

This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living. These tasks are limited to nonmedical personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of repositioning, assisting the individual with walking, and moving the individual from place to place. Waiver Participant instruction in self-care may also be provided; may also include assistance with preparation of meals but does not include the cost of the meals themselves.

The unit of service can be 15 minutes or per diem.

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	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: Supplemental Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

State of California, CCR, Title 22, §§74600 et seq.

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.

Frequency of Verification:

Prior to/at time of initial contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Supplemental Personal 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Adult Day 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:**

Adult Day Care (1.1)
This service will be provided to Waiver Participants who will benefit from being in a social setting. Adult day centers are community-based programs that provide nonmedical care to persons 18 years of age or older in need of personal care services, supervision or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis.

The unit of service can be 15 minutes or per diem.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day 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

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

Assistive Technology (2.6)

Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology includes:
(A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; applying, maintaining, repairing, or replacing assistive technology devices;
(C) services consisting of selecting, designing, fitting, customizing, adapting;
(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the care plan.
(E) the costs associated with delivery and repairs of the items allowable under this service are also included.

The following criteria must be met and documented in the case record:
1. The item is necessary to preserve the Waiver Participant's health, improve functional ability and assure maximum independence thereby preventing elevation to a higher level of care and avoiding more costly institutionalization.
2. The Waiver Participant's assessment must identify the need for this service including how it is a necessary support if the Waiver Participant is to remain in the community, and the care plan specifies the required item.
3. The items are unobtainable through other resources, and the Waiver Participant does not have the funds to purchase the items.

The unit of service for assistive technology is each.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A.

Verification of Provider Qualifications

Entity Responsible for Verification:

MSSP sites arrange for purchased services by contracting with local vendors. The State specifies the qualifications required for each type of vendor and mandates that each site have a vendor contract process. The vendor qualifications and contracting process are verified by the State in the UR process.

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:

Communication: Device

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:**

Communication: Device (9.2)
This service allows the rental/purchase of 24-hour emergency communication and assistance services, or installation of a telephone, to assist in communication for Waiver Participants who are at risk of institutionalization due to conditions likely to result in a medical emergency. Purchase of emergency communication and assistance services are limited to those Waiver Participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Emergency communication and assistance services enable the recipient to secure immediate assistance in the event of an emotional, physical, or environmental emergency; training, installation, repair, maintenance, and response are included. Hearing aids and appliances, and monthly telephone charges are excluded.

The following are allowable:

1. 24-hour answering/paging
2. Medic-alert type bracelets/pendants
3. Intercoms
4. Emergency Response System
5. Light fixture adaptations (blinking lights, etc.)
6. Telephone adaptive devices not available from the telephone company
7. Room monitors

This service is limited to additional services and items not otherwise covered under the state plan, but are consistent with Waiver objectives of avoiding institutionalization. Telephone installation will only be authorized to enable the use of telephone based electronic response systems where the Waiver Participant has no telephone, or for the isolated Waiver Participant who has no telephone and who resides where the telephone is the only means of communicating health needs. This service will only be authorized when the Waiver Participant has a medical/health condition that makes him/her vulnerable to medical emergency.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive Emergency Response System (ERS) services. These types of devices are intended to assist in keeping at-risk Waiver Participants safe in the home and are not intended to replace an in-person support staff.

All types of personal emergency response devices shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer’s authorized dealers where possible.

The unit of service for communication: device is a month, purchase, or each.

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, as appropriate for the service to be purchased

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication: Device

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency, as appropriate for the service to be purchased

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Any electronic communication/response device obtained for participant use must be of a type already in general use; product warranties and servicing for the unit must be available. Providers must be confident to meet applicable standards of installation, repair and maintenance of these systems and devices.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Communication: Translation/Interpretation

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):*

Communication: Translation/Interpretation (9.1)
The provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business is essential to maintaining independence and carrying out the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) functions. For non-English speaking Waiver Participant, this service is the link to the entire home- and community-based service delivery system. MSSP resources shall be used to support this service only where family and community resources are unable to meet the need as described in the care plan.

The unit of service for translation/interpretation is 15 minutes.

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	Individual Translators/Interpreters
Agency	Private Nonprofit or Proprietary Agency, as appropriate for the service to be purchased

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication: Translation/Interpretation

Provider Category:

Agency

Provider Type:

Individual Translators/Interpreters

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers shall have:
Fluency in both English and a language other than English; and
Ability to read and write accurately in both English and a language other than English; and
Ability to maintain confidentiality.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP 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: Other Service
Service Name: Communication: Translation/Interpretation

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency, as appropriate for the service to be purchased

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services (Combined)

HCBS Taxonomy:

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

Service Definition (Scope):

Community Transition Services (2.4) The revised implementation date of this service to begin is December 31, 2023.
These services allow for non-recurring moving and/or housing set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community. Eligible Waiver participants are those who reside in a facility/institution or care provider-owned residence and are transitioning from a facility/institution to their own home or apartment in the community where the participant is directly responsible for his or her own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:
(a) security deposits that are required to obtain a lease on an apartment or home;
(b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
(c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
(d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
(e) moving services, which may include materials and necessary labor;
(f) activities to assess need, arrange for and procure need resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the care plan development process, clearly identified in the care plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

The unit of service for Community Transition Services is service. The cost of such services are considered incurred and billable when the person leaves the institutional setting and enters the Waiver.

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	Public or Private Utility Company
Agency	Private Nonprofit or Proprietary Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services (Combined)

Provider Category:

Agency

Provider Type:

Public or Private Utility Company

Provider Qualifications

License *(specify):*

Public Utilities Commission.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services (Combined)

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services: Housing & Utility Set-up

HCBS Taxonomy:

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

Service Definition *(Scope):*

Community Transition Services: Housing and Utility Set-up (2.5) Effective December 31, 2023, these services will be provided under Community Transition Services: Combined.
This service allows for one-time set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community. Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the care plan development process, clearly identified in the care plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

The unit of service for Housing & Utility Set-up is an event. The cost of such services are considered incurred and billable when the person leaves the institutional setting and enters the Waiver.

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
Agency	Public or Private Utility Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services: Housing & Utility Set-up

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services: Housing & Utility Set-up

Provider Category:

Agency

Provider Type:

Public or Private Utility Company

Provider Qualifications

License *(specify):*

Public Utilities Commission.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services: Moving Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Community Transition Services: Moving Services (2.4) Effective December 31, 2023, these services will be provided under Community Transition Services: Combined.
This service involves facilitating a smooth transition from a facility/institution or care provider-owned residence. Eligible Waiver Participants are those who reside in a facility/institution or care provider-owned residence and require assistance with relocation from a facility/institution to their own home or apartment in the community, or to/from a care provider owned residence. Services may be provided by moving companies or other individuals who can guarantee the safe transfer of the Waiver Participant's possessions. Activities may include materials and labor necessary for such moves.

The unit of service for emergency move is an event. The cost of such services are considered incurred and billable when the person leaves the institutional setting and enters the Waiver.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services: Moving Services

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Consultative Clinical Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Consultative Clinical Services (4.3)
This service addresses the unmet needs of Waiver Participants when such care is not otherwise available under the state plan. These services will be provided based on the following criteria:
* The Waiver Participant assessment identifies need for this support and the care plan reflects the required service(s).
* MSSP utilizes all of the services available under the state plan prior to purchasing these services as Waiver Services. MSSPs Waiver Participants are extremely frail and, on occasion, in need of services that cannot be provided under Medi-Cal. This service is especially critical for persons recently discharged from acute hospitals or who are otherwise recovering at home from an acute illness or injury. This MSSP service supplements, but does not supplant, benefits provided by the state plan.

In addition to the provision of care, Waiver Participants and their families/caregivers are trained in techniques which will enable them (or their caregivers) to carry out their own care whenever possible.

Allowable services are:
- Social services consultation
- Legal and paralegal professionals' consultation
- Dietitian/Nutrition consultation
- Pharmacy consultation
- Vital sign monitoring

The unit of service can be per 15 minutes, hour, diem, visit, or month.

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

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

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	Social, Legal and Health Care Professionals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical Services

Provider Category:

Agency

Provider Type:

Social, Legal and Health Care Professionals

Provider Qualifications

License *(specify):*

State of CA business license

Certificate *(specify):*

N/A

Other Standard *(specify):*

Social, legal and health care professionals must be licensed/certified in their appropriate professional field and be qualified to provide the contracted service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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 Home Repairs and Maintenance

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):*

Minor Home Repairs and Maintenance (2.2)
These services are necessary to ensure the health, welfare and safety of the Waiver Participant in their physical residence or home setting. As specified in the Waiver Participant's care plan, services may include provision of physical adaptions including the installation of ramps and grab bars, widening of doorways, modification of the bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

These services do not involve major structural changes or major repairs to the dwelling. Maintenance is defined as those services necessary for accessibility; items above what is covered by the state plan and, installation, safety, or security. Eligible Waiver Participants are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence. This service is limited to Waiver Participants who are owners/occupiers of their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special Waiver Participant needs. Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

The unit of service for minor home repairs is per service.

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	Minor Repair/Maintenance - Building Contractor
Agency	Minor Repair/Maintenance - Handyman
Agency	Private Nonprofit or Proprietary Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Repairs and Maintenance

Provider Category:

Agency

Provider Type:

Minor Repair/Maintenance - Building Contractor

Provider Qualifications

License *(specify):*

State of California Building Contractor License.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Sites must assure that the vendor for repair jobs that cost more than $1000 (total for materials and labor) is a licensed contractor; is bonded, insured, and has a local business license. Hourly handymen must have a local business license.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Minor Home Repairs and Maintenance

Provider Category:

Agency

Provider Type:

Minor Repair/Maintenance - Handyman

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Sites must assure that the vendor for repair jobs that cost more than $1000 (total for materials and labor) is a licensed contractor; is bonded, insured, and has a local business license. Hourly handymen must have a local business license.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Repairs and Maintenance

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Money Management

HCBS Taxonomy:

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

Service Definition *(Scope):*

Money Management (8.5)
This service assists the Waiver Participant with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions. These Waiver Participants may be isolated by geography or by not having a trustworthy other person to rely upon. Failure to meet personal financial obligations frequently results in eviction, disconnection of utilities, or jeopardizes eligibility for maintenance programs such as Supplemental Security Income (SSI) and Medicaid. Money management services ensure a stable living environment and thereby avoid institutionalization.

The unit of service for money management is per 15 minutes.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Non-profit or Proprietary Agency, or Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Money Management

Provider Category:
Agency
Provider Type:

Private Non-profit or Proprietary Agency, or Individual

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must be bonded and insured.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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 Home Equipment

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):*

Non-Medical Home Equipment (2.3)
This service includes equipment and supplies which address a Waiver Participant's functional limitation and/or condition, are necessary to assure the Waiver Participant's health, safety and independence, and are not otherwise provided through this Waiver or through the Medicaid state plan.

Allowable items:
- Small appliances
- Large appliances
- Furniture
- Home safety devices
- Clothing related items
- Paperwork related/ Organizing items
- Household items (Items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home)
- Kitchenware
- Bedding/Bath items
- Exercise equipment
- Social support/ Therapeutic activity supplies
- Personal care items (Items related to personal care and the prevention of skin breakdown)
- Health related supplies (Items that have a health component, but are not covered by the State Plan)
- Incontinence supplies (gloves, wipes, washcloths and creams)

The following criteria must be met and documented in the case record:
1. The item is necessary to preserve the Waiver Participant’s health, improve functional ability and assure maximum independence thereby preventing elevation to a higher level of care and avoiding more costly institutionalization.
2. The Waiver Participant’s assessment must identify the need for this service including how it is a necessary support if the Waiver Participant is to remain in the community, and the care plan specifies the required item.
3. The items are unobtainable through other resources, and the Waiver Participant does not have the funds to purchase the items.

Experimental or prohibited treatments are excluded as well as those items and services solely for entertainment or recreation. Items included in this service must not circumvent other restrictions on the claiming of FFP for Waiver services, including the prohibition against claiming for the costs of room and board. The costs associated with delivery and repairs of the items allowable under this service are also included.

The unit of service for non-medical home equipment is each.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Home Equipment

Provider Category:

Agency

Provider Type:

Private Nonprofit or Proprietary Agency

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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 Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Nutritional services in the aggregate will not constitute "Board" (three meals per day).

Congregate Meals (7.1)
Meals served in congregate meal settings for Waiver Participants who are able to leave their homes or who require the social stimulation or a group environment in order to maintain a balanced diet.

The unit of service for congregate meals is per diem.

Home-Delivered Meals (7.2)
Home-Delivered Meals are provided to Waiver Participants who are unable to prepare their own meals and have no caregiver at home to prepare meals for them.

The unit of service for home-delivered meals is a meal.

Oral Nutritional Supplements (7.3)

If an MSSP Waiver Participant can benefit from the purchase of Oral Nutritional Supplement (ONS) and Waiver Services will be used to purchase the supplement, the following actions must occur and be documented in the Waiver Participant record:
- The Nurse Care Manager (NCM) must assess the Waiver Participant's nutritional needs and determine that an ONS is advisable.
- The use of home-prepared drinks/supplements did not benefit the Waiver Participant's health.
- All other options for payment of ONS have been exhausted (Waiver Participant, family, etc.).

If all three criteria have been satisfied, ONS may be purchased initially for a period of three months. If ONS needs to be continued beyond the three-month timeframe, a physician order must be obtained.

The unit of service for Oral Nutritional Supplements is each.

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	Title III (Older Americans Act)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Services

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):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Services

Provider Category:

Agency

Provider Type:

Title III (Older Americans Act)

Provider Qualifications

License *(specify):*

Local business license; and any others as required by local government and/or health department inspection.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Social Support

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:**

Social Support (8.3)
This service includes periodic telephone contact, visiting or other social and reassurance services specified in the care plan, to verify that the individual is not in medical, psychological, or social crisis; or to offset isolation. Such services shall be provided based on need, as designated in the Waiver Participant's care plan. MSSP has found that isolation and lack of social interaction can seriously impact some participants' capacity to remain independent. These services may be purchased under the Waiver only if otherwise unavailable in the community.

Social Support services do not duplicate other services provided under the Waiver. The service is non-medical care and does not provide hands-on nursing care.

The unit of service for social support can be 15 minutes or per diem.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Nonprofit or Proprietary Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Support

Provider Category:
Agency
Provider Type:
Private Nonprofit or Proprietary Agency
Provider Qualifications
License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

All individuals performing these services must:
* Be a US citizen or legal alien;
* Be at least 18 years of age;
* Have a Social Security card;
* Be able to read, write, carry out directions, and maintain simple records;
* Have transportation available;
* Be able to communicate changes in the status of the participant and/or family; and
* Be physically capable of performing the work required.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Supplemental Protective Supervision

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:**

Supplemental Protective Supervision (3.7)
This service ensures the regular provision of supervision in the absence of the usual care provider to persons in their own homes who are very frail or otherwise may suffer a medical emergency, to prevent immediate placement in an acute care hospital, nursing facility, or other 24-hour care facility. Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. May also provide a visit to the Waiver Participant's home to assess the situation during an emergency. Waiver Service funds may not be used to purchase this service until existing state plan resources have been fully utilized and an unmet need remains.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive Emergency Response System (ERS) services.

The unit of service can be 15 minutes or per diem.

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
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Protective Supervision

Provider Category:

Agency

Provider Type:

Private nonprofit or proprietary agency

Provider Qualifications

License *(specify):*

Local business license.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Tasks authorized under Protective Supervision (3.7) are specified in the
California DSS Manual, Division 30, Chapter 30-757. All individuals performing these services must:
* Be a US citizen or legal alien;
* Be at least 18 years of age;
* Have a Social Security card;
* Be able to read, write, carry out directions, and maintain simple records;
* Have transportation available;
* Be able to communicate changes in the status of the Waiver Participant and/or family; and
* Be physically capable of performing the work required.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Protective Supervision

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

State of California, CCR, Title 22, §§74600 et seq.

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.

Frequency of Verification:

Prior to/at time of initial contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Therapeutic 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:

Therapeutic Counseling (8.4)
This service includes individual or group counseling to assist with social, psychological, or medical problems identified on the care plan. Therapeutic counseling is essential for preventing some Waiver Participants from being placed in a nursing facility (NF). This service may be utilized in situations where Waiver Participants or their caregivers may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems. Counseling by licensed or certified counselors in conjunction with other services may reverse some states of confusion and greatly enhance the ability of a family to care for the Waiver Participant in the community; or allow the Waiver Participant to cope with increasing impairment or loss.

The unit of service for therapeutic counseling is per 15 minutes. Therapeutic Counseling is only allowable when state plan services have been exhausted, or are not otherwise available under the approved Medicaid state plan.

The participant may choose to receive Therapeutic 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:

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	Licensed/certified Professionals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Counseling

Provider Category:
Agency
Provider Type:

Licensed/certified Professionals
Provider Qualifications
License *(specify):*

Local business license.
Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers are professionals who are licensed or certified to practice in the State of California. The licensing authority for clinical social workers, marriage and family counselors and therapists, psychologists and psychiatrists is the California Department of Consumer Affairs, Boards of Behavioral Science Examiners and Medical Quality Assurance. The certification authority for rehabilitation counselors is the Commission on Rehabilitation Counselor Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Therapeutic Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Counseling and Therapeutic Services: Therapeutic Services (3.3)
This service addresses unmet needs of Waiver Participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:
• The Waiver Participant assessment identifies need for this support and the care plan reflects the required service(s).
• MSSP Waiver Participants are extremely frail and, on occasion, in need of services that cannot be provided under that cannot be provided under Medi-Cal. This MSSP service supplements but does not supplant benefits provided by the state plan.

Therapeutic Services includes the following: foot care, massage therapy, and swim therapy. The unit of service can be per 15 minutes, diem, or visit.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Services

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/

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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:

Transportation

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):*

Transportation (6.3)
Service offered in order to enable Waiver Participants to gain access to waiver and other community services, activities and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the state plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the Waiver shall be offered in accordance with the Waiver Participant's care plan and shall include transportation escort, if necessary, to assure the safe transport of the participant. Transportation escort services may be authorized for those Waiver Participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider. The rate includes the cost of the companion should that be required.

The unit of service for regular transportation is an hour.

Transportation(One-Way Trip)(6.4)
Service offered in order to enable Waiver Participants to gain access to waiver and other community services, activities and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the state plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the Waiver shall be offered in accordance with the Waiver Participant's care plan and shall include transportation escort, if necessary, to assure the safe transport of the participant. Escort services may be authorized for those Waiver Participants who cannot manage to travel alone, and require assistance beyond what is normally offered by the transportation provider.

The unit of service for transportation one-way-trip is each.

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	6.3 Transportation (hour) - Private nonprofit or proprietary agency or Ambulance or wheelchair van/paratransit.
Agency	6.4 Transportation (one-way trip) - Private nonprofit or proprietary agency or Ambulance or wheelchair van/paratransit

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency

Provider Type:

6.3 Transportation (hour) - Private nonprofit or proprietary agency or Ambulance or wheelchair van/paratransit.

Provider Qualifications

License *(specify):*

Drivers must possess a valid class II or III driver's license issued by the California State Department of Motor Vehicles. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract.
Providers of ambulance services must have a California Highway Patrol (CHP) vehicle inspection certificate; drivers must have successfully completed ambulance attendant training. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract.

Providers of wheelchair van/paratransit services must provide evidence of CHP inspection and driver training. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers of escort services must be experienced in serving the needs and conditions of frail older adults. In communities where the need for this service cannot be met through agency providers of 3.1 Homemaker Services described above, individuals may be used, provided they have documented on the MSSP Service Vendor Application an appropriate degree of experience and insurance, and reference checks verified by MSSP staff confirm a history of satisfactory performance.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

6.4 Transportation (one-way trip) - Private nonprofit or proprietary agency or Ambulance or wheelchair van/paratransit

Provider Qualifications

License *(specify):*

Providers of regular transportation services must be either a properly registered private nonprofit or a licensed proprietary agency. Drivers must possess a valid class II or III driver's license issued by the California State Department of Motor Vehicles. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract.
Providers of ambulance services must have a California Highway Patrol (CHP) vehicle inspection certificate; drivers must have successfully completed ambulance attendant training. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract.
Providers of wheelchair van/paratransit services must provide evidence of CHP inspection and driver training. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The MSSP site administrator.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter, or before the license expiration date, whichever is sooner.

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):

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- (●) **No. The state does not conduct abuse registry screening.**
- ( ) **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

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

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

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

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

☐ **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 timeframes or restrictions on potential providers under the MSSP Waiver. Any willing and qualified provider may contract with the MSSP site, or elect to become a Medi-Cal Provider and bill directly for services.

For providers other than MSSP sites, instructions for how to enroll as a Medi-Cal provider, along with requirements and procedures, are provided on the DHCS website, Provider Enrollment Division section. There is an electronic application process, with Q&A/Training Webinars available online: dhcs.ca.gov/provgovpart/Pages/PED.aspx

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Percent of MSSP sites who certify at initial time of hire and/or subsequent renewal and report quarterly to CDA that all of their care managers [Registered Nurse (RN) and Social Worker] meet the minimum qualifications. Numerator: Number of MSSP sites who certify and report quarterly that all of their care managers meet the minimum qualifications. Denominator: Total number of sites.

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

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: Two year contracts

Performance Measure:
Vendors initially and continually meet required licensure and/or certification standards and adhere to other standards prior to the provision of Waiver Services. Numerator: Number of vendors that initially and continually meet qualifications and licensure requirements. Denominator: Total number of licensed/certified vendors reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor files reviewed.

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%, with a margin of error +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Each site, every two years	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

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:
CDA contracts with MSSP sites require that all care management staff receive annual training and credential validation. Numerator: Sites that certify staff by annual training. Denominator: Total number of sites.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Quarterly Report from sites

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
MSSP site contracts with Waiver Service vendors require that annual training is conducted in accordance with state requirements and the approved Waiver. Numerator: Vendors that complete annual training. Denominator: Total number of vendors reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor files reviewed

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%, with a margin of error +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Each site, every two years	

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.

CDA assures that the Waiver Services delivered to MSSP Waiver Participants by the MSSP sites are provided by qualified vendors. The contract between CDA and the MSSP site requires that the site maintain sufficient written vendor agreements for continuous availability and accessibility of all services identified in each Waiver Participant's care plan at all times. MSSP sites must have a formal process for vendor selection and must have agreements with responsible well-qualified vendors. In the selection process sites assure that Waiver Services vendors meet required licensing standards. Each vendor of services must complete a specified MSSP Vendor Application Form that is to be retained and filed with the final vendor contract or agreement. Sites must maintain copies of current license and insurance documents. Sites must take appropriate action when a vendor does not maintain the license or insurance coverage(s) specified. Sites are required to submit a Vendor Licensing Form to CDA at the beginning of each fiscal year (this information is later used in the CDA Utilization Review (UR) process (see below). This report summarizes licensing and insurance information for each vendor. Vendor performance is monitored by the MSSP sites on an ongoing basis. Monitoring of vendor performance is necessary to insure the delivery of quality services to participants. Sites establish formal methods of monitoring and communicating information on vendor performance which give consideration to the following elements: the receipt and recording of complaints/issues; a logging/tracking method; timely handling and resolution; confidentiality; and documentation of patterns, trends and special problems. Sites report all vendor issues and resolutions to CDA quarterly.

CDA monitors the local service vendor process through the UR process. Services are tracked from the selected Waiver Participant files to the local site vendor contracts for each of those records to ensure that the Waiver Participant services were provided by qualified providers. Should deficiencies be found, Corrective Action Plans (CAPs) are required of the site. These CAPS are monitored and reviewed and, when the deficiencies are corrected, the CAP is approved by the CDA MSSP Bureau. CDA provides follow-up technical assistance in all instances.

CDA uses an automated UR monitoring tool to aggregate data from the monitoring and oversight to analyze statewide trends to provide problem resolution with technical assistance and training.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

For information regarding the Waiver specific transition plan, please refer to Attachment #2 in this application.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Care Plan (CP)

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:*

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 MSSP, he/she is provided a description of Waiver Services, limitations, and requirements, and any feasible alternative programs. The individual is then given the choice between the MSSP Waiver and other care and/or institutionalization options and between Waiver Services and providers. The Waiver Participant acknowledges that they were given the above choices by signing the MSSP Application.

The Waiver Participant is required to be involved in the care plan process and indicate their agreement with all services by signing the care plan. Before the care plan is reviewed and before signature, the MSSP care manager is required to offer freedom of choice for services and service providers, as well as the option to include others in the care plan 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):

Waiver Participant centered care plans are developed collaboratively with the Waiver Participant by the MSSP Nurse and Social Work care managers based on the health and functional needs of the Waiver Participant. Upon entry into MSSP, each Waiver Participant receives face-to-face comprehensive initial health and psychosocial assessments to determine the Waiver Participant's specific problems, resources, strengths, needs, goals and preferences. Reassessments are completed annually and form the basis for subsequent annual care plans. Changes can occur anytime based on changes in the Waiver Participant's situation. The care plan must be developed within two weeks of the assessments.

The Waiver Participant is involved in the development of the care plan and has a choice in service selection. The Waiver Participant signs the care plan to indicate their acceptance of the plan. When an individual is determined to be eligible for MSSP, he or she is provided a description of Waiver Services, limitations, and requirements, and any feasible alternative programs. The individual is then given the choice between the MSSP and other care/institutionalization options and between Waiver Services and providers. The Waiver Participant, or their authorized representative, if appropriate, acknowledges that they were given the above choices by signing the MSSP Application.

The care plan documents problems and organizes the Waiver Participant's service delivery system including MSSP and other community services. The care plan is kept current by the MSSP Care Manager through ongoing monitoring with at least monthly telephone contact and quarterly face-to-face visits to assure that the services are meeting the Waiver Participant's needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The care management assessment processes include risk assessment, evaluation of the Waiver Participant's physical environment, and the potential for abuse, neglect and exploitation. Care plans are developed in coordination with the Waiver Participant and their support system and address arrangements for implementing backup plans.

MSSP Waiver Participants have the right to refuse specific service(s) or to subject themselves to risk. However, when a Waiver Participant refuses a service, the site must have a process of assuring that the risks associated with the refusal are addressed.

MSSP care plans reflect the participation and concurrence of the Waiver Participant. However, there are situations where the Waiver Participant chooses to pursue a course of action or behavior that the care manager may determine is unwise; or the Waiver Participant may refuse services that, in the judgment of the care manager, are necessary to live safely. In most instances, it is sufficient to document the situation, including that the Waiver Participant was informed of the possible consequences of their decision. There are, however those situations where there is a high possibility of an adverse outcome: e.g., smoking while using oxygen, an uncontrolled diabetic refusing to follow their diet. Participants do have the ultimate right to assume risk commensurate with their ability and willingness to understand and assume responsibility for the consequences of that risk. Risk assessment facilitates the systematic exploration of situations that have a high possibility for adverse outcome.

The status of the risk management plan should be monitored during regular monthly contacts by the care manager. It should be formally reviewed or renewed at intervals mutually agreeable to the Waiver Participant and care manager. These intervals will be determined by the nature of the individual situation.

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.

When a Waiver Participant is determined to be eligible for MSSP, he or she is provided a description of Waiver Services, limitations, and requirements, and any feasible alternative programs. The Waiver Participant is then given the choice between the MSSP and other care/institutionalization options and between Waiver Services and providers. The Waiver Participant acknowledges that they were given the above choices by signing the MSSP Application.

The care manager is responsible for informing each Waiver Participant of the feasible alternatives for obtaining necessary services and giving each eligible Waiver Participant the choice of receiving necessary care and services in a nursing facility or in an in-home living arrangement. The Waiver Participant's assigned care manager is also the person at the local MSSP site responsible for informing the Waiver Participants (or their representative) of the feasible service alternatives and choice of living arrangements.

The care manager shall ensure that:

Waiver Participants or their legal representative are informed of the choice of either participating or not participating in the MSSP Medicaid Waiver program.

The Waiver Participant is informed regarding the site's informal grievance procedure and formal appeal rights; termination procedures; and the Waiver Participant's right to refuse or discontinue services.

The Waiver Participant's choice is documented on the Application form at time of:

1. Initial application for the Waiver program, or

2. Reapplication after a participant's termination from participation in the program.

Waiver participants are given free choice of all qualified Waiver providers for each service included in their care plan.

Participants are contacted at minimum once per month, either by telephone or face-to-face in the participant’s home. At that time, the care manager reviews the service/care plan with the participant and discusses alternative and qualified providers as necessary.

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):

With input and approval from DHCS, CDA created the MSSP Site Manual outlining appropriate service/care plan format and content. CDA, through Interagency Agreement with DHCS, reviews a sample of service/care plans during the Utilization Review (UR) process, which is based on a collaboration with DHCS to ensure all Waiver requirements are met. The UR team analyzes a sample of case records, progress notes, assessment/reassessments, individual care plans, and any other documentation used to develop the Waiver Participant's plan of care to ensure that the CP is appropriate for the Waiver Participant. All findings related to service/care plans are included in UR reports to the MSSP sites.

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

DHCS' review of CDA UR Reports and CAPs occurs on an ongoing basis. Additionally, DHCS may accompany the CDA team during Utilization Reviews, as needed, to ensure all programmatic and Waiver requirements are being met. DHCS maintains authority to conduct independent on-site visits to address deficiencies and to train/educate the MSSP sites as appropriate. DHCS and CDA hold regular monthly calls to discuss Utilization Reviews, including any service/care plan related findings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☒ **Other**

Specify:

The local MSSP sites.

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.

Service/care plan implementation and monitoring are performed by the local MSSP site. Service needs are identified and services are arranged for during the care planning process. The care plan is kept current by the Waiver Participant's care manager through ongoing monitoring with at least monthly telephone contact and quarterly face-to-face visits to assure that the services are meeting the Waiver Participant's needs. Review, discussion and updating of the care plan 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 Waiver Participant's record.

During the monthly contacts and quarterly face-to-face visits, the care manager will go through the process of offering different providers for different services as well as determining if the participant is satisfied with current services. For example, if a participant is not satisfied with the timeliness of services provided through a company that offers personal care supplies, the care manager will offer the use of another company that provides personal care supplies.

Changes can occur anytime based on changes in the Waiver Participant's situation. The care plan is a living document; therefore, it is always changing and evolving to best meet the participants' needs during the course of the care plan.

Each participant has a care plan designed by the care manager in concert with the participant. Part of the process in developing the care plan is to determine real needs that will or may affect the participant's health and welfare. Each determined need is written in the care plan as a "participant need statement." Each participant need statement is assigned an intervention(s) to alleviate that need and a corresponding goal statement. The need, intervention, and goal statements are reviewed with the participant every month through telephone contact or face-to-face visits. If the goal(s) are not being met, the care plan may be updated with a more appropriate and/or effective intervention to ensure the participant's health and safety.

If care plan deficiencies are identified during the Utilization Review (UR) process, the CDA UR team documents them in the UR Tool, which are then compiled by the team by the end of the review. Trends are identified and a written report of the findings and recommendations is issued to the site, which will include a formal written request for a Corrective Action Plan (CAP) specific to remediating the deficiencies. The site is required to respond to CDA within 30 days of the date of the UR report and develop a formal CAP to address any deficiencies identified. Upon receipt of the CAP, CDA monitors the site's resolution process to ensure complete remediation of the deficiency. The site does not receive a CAP approval letter until complete resolution has been verified by CDA. Technical assistance is provided throughout the process on an as needed basis. All UR Reports and CAP approval letters are sent by CDA to DHCS for review on a flow basis.

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:*

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:
The percentage of Waiver Participants whose service plans are adequate and appropriate to address their needs and personal goals as indicated in the assessment.
Numerator: Number of Waiver Participants whose service plans are adequate and appropriate to address their needs and personal goals as indicated in the assessment.
Denominator: Total number of cases reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 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:
The percentage of cases with Waiver Participant signature on the service plan(s) (indicating their involvement, satisfaction with services and approval of their service plan). Numerator: Number of cases with the Waiver Participant's signature on the service plan(s). Denominator: Total number of cases reviewed.

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

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

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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.

Performance Measure:
The percentage of Waiver Participants whose service plan is based upon MSSP approved assessment tools. Numerator: Number of Waiver Participants whose service plan is based upon MSSP approved assessment tools. Denominator: Total number of cases reviewed.

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

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

		95%, with a margin of error +/- 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:

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:
The percentage of Waiver Participants whose service plan was revised to address the Waiver Participant's changing needs. Numerator: Number of Waiver Participants whose service plan was revised to address the Waiver Participant's changing needs. Denominator: Total number of cases reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 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:
The percentage of cases where service plans were reviewed and revised before the Waiver Participant's annual review date. Numerator: Number of cases where service plans were reviewed and revised before the Waiver Participant's annual review date. Denominator: Total number of cases reviewed.

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

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

		Sample Confidence Interval = 95%, with a margin of error +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
The percentage of Waiver Participants who receive services that match their service plan. Numerator: Number of Waiver Participants who receive services that match their service plan. Denominator: Total number of cases reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 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:
The percentage of Waiver Participants who received at a minimum a monthly telephone contact and a quarterly home visit by the Waiver Participants Care Manager. Numerator: Number of Waiver Participants who received at a minimum a monthly telephone contact and a quarterly home visit by the Waiver Participants Care Manager. Denominator: Total number of cases reviewed.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
The percentage of Waiver Participants who receive documentation on: 1) freedom of choice between Waiver Services and institutional care; and 2) freedom of choice between service provider or vendor. Numerator: Number of Waiver Participants who receive documentation. Denominator: Total number of cases reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

If errors are identified in the service plan or service delivery during the UR process, a written report of the findings and recommendations is issued to the site from CDA that will include a formal written request for a corrective action plan (CAP) specific to remediating the errors. The site is required to respond to CDA and develop a formal plan to cover any deficiencies identified; the plan is then monitored by CDA and when the problem is remediated, the CAP is approved. Technical assistance is provided on an as needed basis.

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.

MSSP Waiver Participants/applicants will be informed, by a Notice of Action (NOA) letter, of their ability to appeal an adverse decision regarding Waiver enrollment or Waiver Services. A NOA will be sent, by the applicable MSSP site, to the applicant, existing Waiver Participant and/or conservator when a request for enrollment in the Waiver is denied, or when a Waiver Service has not been approved as requested, is reduced, suspended, terminated or denied. If there is disagreement with a decision, the applicant, Waiver Participant and/or conservator has the right to request a fair hearing. The State Fair Hearing (SFH) process, including the request, preparation and procedure is found in the Code of California Regulations, Title 22, Division 3, Subdivision 1, Chapter 2, Article 18, Section 50951; and Welfare and Institutions Code, Sections 10950-10965.

Individuals will be notified within ten calendar days of a decision when the MSSP site:
- Denies an initial request for Waiver enrollment
- Denies a request for a new Waiver Service not currently being provided
- Denies continuation of a Waiver Service currently authorized
- Approves continuation of a Waiver Service currently authorized but modifies it (to reduce or suspend the frequency or duration of previously authorized Waiver services)
- Changes the place or provider of service
- Denies the Waiver Participant choice of Waiver provider(s), except when the provider of choice is unavailable or does not have the capability and capacity to accept and provide the anticipated level of care or intensity based on acuity, age and other factors
- Discontinues the Waiver Participant's eligibility for the Waiver

Examples of NOAs and SFH Forms are located in the Appendices and Forms sections of the MSSP Site Manual, which is available on the MSSP website online. The NOA will include instructions advising the applicant, Waiver Participant and/or authorized representative on how and where to request a SFH before an Administrative Law Judge (ALJ) and that the SFH request must be filed within 90 calendar days of the date of the NOA. If the NOA concerns the reduction, suspension, or termination of currently authorized services, and the Participant or conservator wishes these services to continue during the SFH process, then this must be stated in writing in the request for an SFH.

A request for an SFH is considered late if submitted after the 90 calendar days. All late requests for a SFH will be denied. The written decisions will be final unless the applicant, participant and/or authorized representative demonstrate in writing, good cause for the late filing. The decision regarding good cause will be made by the Hearing Officer.

The Waiver Participant's Waiver eligibility may be affected in cases where the NOA was issued because the Waiver Participant no longer met Waiver requirements or regular Medi-Cal eligibility requirements.

The same procedures for requesting a SFH apply to MSSP participants whether fee-for-service or managed care.

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.

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:

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).

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).

MSSP sites are responsible for addressing the health and welfare needs of each Waiver Participant on an on-going basis. MSSP Care Managers are mandated reporters under California's Adult Protective Services (APS) Program and immediately report instances of abuse, neglect or exploitation, as required by California law (California Welfare and Institutions Code Section 15630(b)(1)), to the local county APS or law enforcement agency who investigate and resolve the reports. Incidents are identified and documented within the care plan process. MSSP Care Managers continuously monitor the progress and resolution. Outcomes are documented in the Waiver Participant's progress notes or care plan.

In California, all individuals providing or monitoring health care are considered mandated reporters. Mandated reporters must file a report of suspected abuse immediately, or as soon as practically possible and within two working days of making the telephone report to the responsible local agency. A MSSP Care Manager who has knowledge of or observes a MSSP Waiver Participant in his/her professional capacity (or within the scope of his or her employment) whom he/she knows or reasonably suspects has been the victim of abuse, neglect or exploitation, is required to report the known or suspected instance to an Adult Protective Agency immediately or as soon as practically possible by telephone. Furthermore, any individual may report any critical event, incident or complaint concerning the health and safety of any Waiver Participant at any time.

The MSSP Care Manager will document all reported or observed critical events or incidents that may affect the health, safety and welfare of Waiver Participants. The MSSP Care Manager will report all incidents to the local APS 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 Waiver Participant; fraud or exploitation (including misuse of Participant's funds and/or property); or an unsafe environment.

The MSSP Care Manager will update the Waiver Participant file and the MSSP site will report the incident as part of their Quarterly Report to CDA.

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.

Each local MSSP site is responsible for providing critical incidents training and orientation including APS reporting to all MSSP staff. At the time of enrollment the MSSP Care Manager reviews with the individual Waiver Participant enrollment materials including Waiver Participant bill of rights and information on how to recognize and report abuse, neglect and/or exploitation.

MSSP sites provide education to the participant and/or family members or caregivers on an ongoing basis as needed. Education that is provided is documented by MSSP staff in the monthly progress notes of the participant’s record. The content of follow up activities should include providing education to the participant/family and other informal support persons so that services provided by the informal support network can continue at the existing or an increased level.

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 Adult Protective Services (APS) and local law enforcement 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 MSSP sites.

Each MSSP site is responsible for providing critical incidents training and orientation, including APS reporting, to all MSSP staff.

During monthly phone calls and quarterly home visits, MSSP Care Managers ascertain whether any critical incidents have occurred, report them to the appropriate agencies (APS, law enforcement, etc.), then document the incident(s) in the progress notes and add to the care plan interventions when applicable. The total number of critical incidents are tracked by the sites and reported to CDA quarterly.

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

MSSP Care Managers are encouraged to review difficult cases, including critical incidents, with supervising Care Managers and site directors, if applicable. Some MSSP sites incorporate Multidisciplinary Team meetings to review difficult cases, including critical incidents, in order to coordinate with other agencies/entities in implementing interventions on a case-by-case basis. MSSP Care Managers determine if notification of others is warranted. Since MSSP Waiver Participants receive services in their own homes, there is no other licensing agency/entity involved. Any contact made with other agencies or individuals will be kept confidential as required by law. Any egregious critical incidents will be reported to CDA immediately, then CDA will review with DHCS as necessary. CDA is available to the MSSP sites to provide Technical Assistance on a case-by-case basis. Any incidents requiring technical assistance are reviewed by CDA and DHCS as needed during monthly meetings.

CDA has made changes to the MSSP Site Quarterly Report, so that all critical incidents, including processes, timelines, and follow-up are recorded for review. Since California's APS program does not disclose report outcomes due to confidentiality, CDA will be reviewing MSSP site and Waiver Participant reported outcomes on a quarterly basis, with the expectation that the MSSP sites are monitoring and responding to all critical incidents on a monthly basis at a minimum. CDA will aggregate and analyze the quarterly report data to summarize for DHCS review. CDA then coordinates with DHCS during monthly meetings in identifying trends and developing strategies for applying interventions as required. If trends are identified, the MSSP sites will be notified and training will be provided to care management staff.

During the Utilization Review process, CDA cross-references critical incidents reported as part of the MSSP Quarterly Report, then conducts case record reviews to determine:

1. If the Care Manager staff are completing and submitting APS referrals for all events that may or are affecting the participant's health and safety.
2. If an appropriate action plan was developed and documented in the progress notes and/or care plan if applicable.
3. That critical incident issues continue to be monitored during care management calls and home visits until the participant reports the issue(s) has been resolved.
4. If systemic program issues exist that require remediation.

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.

California's Adult Protective Services (APS) program has primary responsibility to resolve reported events/incidents of abuse, neglect and/or exploitation.

In the event that APS does not take timely and appropriate action, Care Managers will notify local law enforcement if the issue is observed to persist.

In the event of involvement of APS and/or local law enforcement, the MSSP Care Manager will continue to monitor the Waiver Participant's health and safety to ensure the issues have been resolved.

MSSP sites report the total number of incidents encountered quarterly, which CDA reviews and tracks by quarter and by site, to determine if trends occur. Upon receipt of the quarterly reports, CDA contacts individual sites to discuss anomalies, providing technical assistance as needed.

CDA has updated the MSSP Quarterly Report to include more information about individual incidents, including:
- Case number (in order to track for recurrence of similar incidents)
- Type of incident (abuse, neglect, exploitation, etc.)
- Type of perpetrator (whether it was a Medi-Cal provider, vendor, etc.)
- Agencies notified (APS, law enforcement, etc.)
- Timeliness of reporting the incident and completion of follow-up interventions
- Specific follow-up actions completed by care management/site staff
- Waiver Participant reported outcome/resolution

This data will allow CDA to quickly identify trends on a quarterly basis and provide technical assistance to the sites as needed. DHCS receives a quarterly summary of all critical incidents from CDA. CDA also tracks any egregious critical incidents where Technical Assistance was provided to the site(s) and will discuss with DHCS at monthly meetings. CDA and DHCS also use these meetings to review any potential trends discovered and discuss appropriate interventions.

During Utilization Reviews, CDA reviews progress notes and care plans to ensure all incidents have been documented and all risks to the participant’s health, safety, and welfare are mitigated. Quarterly reports are cross-referenced to ensure all health and safety issues have been reported. If errors are identified in the participant's records regarding health and welfare issues during the UR process, a written report of the findings and recommendations is issued to the site from CDA. This report will include a formal written request for a corrective action plan (CAP) specific to remediating the errors. The site is required to respond to CDA and develop a formal plan to cover any deficiencies identified; the plan is then monitored by CDA and when the problem is remediated, the CAP is approved. Follow-up visits and technical assistance are provided as needed.

CDA will provide documentation on any critical incidents that have occurred during the waiver cycle to DHCS. DHCS will review, monitor and provide technical assistance as needed to CDA.

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 MSSP sites are responsible for ongoing monitoring and ensuring the health, safety and welfare of Waiver Participants including ensuring that restraints and seclusion are not utilized under any circumstances. The MSSP Care Managers will monitor the Waiver Participant's health and safety at both the monthly contact call and the quarterly face-to-face visits. CDA provides oversight during the utilization 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 MSSP sites are responsible for ongoing monitoring and ensuring the health, safety and welfare of Waiver Participants including ensuring that restrictive interventions are not utilized under any circumstances. The MSSP Care Managers will monitor the Waiver Participant's health and safety at the monthly contact call and the quarterly face-to-face visits. CDA provides oversight during the utilization review process. DHCS will monitor CDA's oversight of the UR process. DHCS will review, monitor and provide technical assistance as needed.

○ **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 state does not permit the use of seclusion. Each local MSSP site is responsible for providing critical incidents training and orientation including APS reporting to all MSSP staff. MSSP Care Managers are responsible for documenting any critical incidents, including seclusion, in the progress notes and care plan if applicable. CDA provides oversight during the Utilization 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:
The percentage of critical incidents, specifically occurrences of abuse, neglect,

exploitation and suspicious death, reported to the appropriate investigative entities (e.g., Law Enforcement, APS) 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):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 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:
The percentage of critical incidents, specifically abuse, neglect, exploitation and suspicious death, that required follow-up (reporting to APS as required under CA Mandated Reporter laws and documenting follow-up in the participant record) was completed. Numerator: Number of critical incidents for which required follow-up was completed. Denominator: Total number of critical incidents reported.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 5%

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
The percentage of critical incidents where the root cause was identified. Numerator: Number of critical incidents where the root cause was identified. Denominator: Total number of critical incidents.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with a margin of error +/- 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:
The percentage of critical incidents reported that have been effectively resolved as reported by the Waiver Participant. Numerator: Number of Waiver Participants that report that critical incidents have been effectively resolved. Denominator: Total number of Waiver Participants that had critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly Report from sites

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:
The percentage of Waiver Participants that did not have a recurrence of similar critical incidents after interventions have been applied. Numerator: Number of Waiver Participants that did not have a recurrence of similar critical incidents within the reporting year. Denominator: Total number of Waiver Participants that had critical incidents reported in the reporting year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly Report from sites

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
The state does not allow the use of restrictive interventions. Numerator: Number of cases that confirmed there was no use of restrictive interventions. Denominator: Total number of cases reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample**

		Confidence Interval = 95%, with a margin of error +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
The percentage of Waiver Participants who report that their health and safety needs are being met by the Waiver. Numerator: Number of Waiver Participants who report that their health and safety needs are being met by the Waiver. Denominator: A representative sample of Waiver Participants.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Utilization reviews (URs) are conducted by the CDA. The utilization review team analyzes a sufficient sample of case records, progress notes, assessment/reassessments, individual care plans, and any other documentation used to develop the Waiver Participant's plan of care to ensure that the care plan addresses all of the Waiver Participant's health and welfare needs.

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.

MSSP sites report the total number of incidents encountered quarterly, which CDA reviews and tracks by quarter and by site, to determine if trends occur. Upon receipt of the quarterly reports, CDA contacts individual sites to discuss anomalies, providing technical assistance as needed. During Utilization Reviews, CDA reviews progress notes and care plans to ensure all incidents have been documented and all risks to the participant's health, safety, and welfare are mitigated. Quarterly reports are cross-referenced to ensure all health and safety issues have been reported. If errors are identified in the Waiver Participant's records regarding health and welfare issues during the UR process, a written report of the findings and recommendations is issued to the site from CDA. This report will include a formal written request for a Corrective Action Plan (CAP) specific to remediating the errors. The site is required to respond to CDA and develop a formal plan to cover any deficiencies identified; the plan is then monitored by CDA and when the problem is remediated, the CAP is approved. Follow-up visits and technical assistance are provided as needed.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The California Department of Aging (CDA) performs an ongoing sampling of MSSP Participant records through its discovery process, the Utilization Review (UR). The CDA UR team analyzes case records, progress notes, assessment/reassessments, the Waiver Participant's plan of care, individual service plans, and any other pertinent documentation. The analysis of these records allows the UR team to determine that documentation was done on a timely basis, with the appropriate forms and done by appropriate personnel. The areas of review include level of care (LOC), care plan, provider services and Participant health and welfare.

When an individual problem is identified during the UR process, a written report of the findings and recommendations is issued to the site from CDA that will include a formal written request for a Corrective Action Plan (CAP) specific to remediating the problem. The site is required to respond to CDA with a formal written plan to cover any deficiencies identified within 30 calendar days. The CAP must be specific about the actions to taken, the personnel who will take the actions, and when the corrective action will be completed. Upon receipt of the CAP, CDA monitors the site's resolution process to ensure complete remediation of the deficiency. Once the CAP is reviewed by the CDA UR team, the site is given an opportunity to implement the developed strategy. Once implementation has occurred, CDA may conduct a Follow-up Visit with the site to evaluate the effectiveness of the site's new practice, and/or requests submission of records for additional review by CDA. The site does not receive a CAP approval letter until complete resolution has been verified by CDA. Technical assistance is provided throughout the process on an as needed basis.

CDA aggregates the results of the site UR discovery information and develops a statewide remediation approach which includes policy dissemination through the periodic MSSP Site Association meetings and through MSSP Site Manual updates and through policy clarification letters. CDA also provides technical assistance through on-going email and telephone contact between the sites and CDA staff. CDA uses this aggregate data to prioritize training needs in order to schedule multi-site training events.

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

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 CDAs remediation activities are analyzed in order to measure their effectiveness. This analysis results in system changes to the URs and UR tools and to methods of policy dissemination, technical assistance and training.

Quarterly, the DHCS staff and management meet to discuss potential trends identified during the quarter. Any trends identified by DHCS in the prior quarter's reviews are presented to CDA during CDA/DHCS quarterly managers' meeting. Following the meeting, DHCS and CDA determine whether a trend exists through additional site monitoring. This monitoring may extend over several quarters depending on the number of site visits possible and the applicability of the possible trend to the scheduled sites.

At the next quarterly managers meeting, both entities compare the results of additional site monitoring from not only the prior quarter, but also during a look-back period mutually agreed upon by both parties depending on the gravity and extent of the trend(s) being identified/validated. If sufficient data have been gathered to make a determination, appropriate steps and system changes are discussed. It is essential that any changes to the quality improvement system (QIS) are incorporated into both the CDA UR tool and the DHCS CAR. The symmetry for this process must be in place in order to perform follow-up activities to measure the system design changes and standards for improvement.

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

Every eighteen months preceding the submission of the CMS - 372, the effectiveness of existing quality assurance systems are reviewed to determine continued efficacy. System changes are identified and mutually agreed upon between DHCS and CDA. The UR review tool and the CAR are changed to reflect mutually agreed upon revisions.

Quality improvement input is also solicited from the MSSP Site Association (MSA) during the three yearly collaborative (advisory) meetings between CDA and MSA.

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):*

As part of the Home and Community-Based Settings Statewide Transition Plan, the California Department of Aging (CDA) performs ongoing Participant Surveys concurrent with Utilization Reviews, in order to review participant experience of care and that all HCBS setting requirements are being met.

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).

The MSSP Waiver providers are subject to the requirement of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). Payments or zero-cost claims (encounters) for Waiver Services are submitted through the approved California Medicaid Management Information System (CA-MMIS). The California Department of Health Care Services (DHCS) CA-MMIS Division administers the Medicaid Management Information System and oversees the State's third-party fiscal intermediary (FI) contract.

MSSP sites must first obtain an MSSP Medi-Cal Waiver Program provider number by submitting to DHCS a completed Medi-Cal Waiver Program, Medi-Cal Provider Application form. Federal regulations require Medicaid programs to ensure program integrity by requiring that providers disclose certain information. California Medi-Cal deters potential fraud and abuse by having the provider complete the DHCS 6207, Medi-Cal Disclosure Statement Form. These application forms are submitted via DHCS/Provider Enrollment Division (PED) to the DHCS/Payment Systems Division (PSD) for processing.

MSSP Waiver Participants have to be enrolled in Medi-Cal. In addition, all MSSP claims or encounters use MSSP-specific modifiers with nationally recognized Healthcare Common Procedure Coding System (HCPCS) procedure codes.

Claims or encounters for Care Management, Care Management Support and other services purchased by local sites for MSSP Participants are submitted by MSSP providers to the California Medicaid Management Information System (CA-MMIS) for payment.

DHCS Audits & Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including MSSP. All claims submitted by Waiver and state plan providers are subject to continuous post-payment review which occurs regardless of provider type, specialty, or service rendered. Scope of records utilized for any audits include claims data, provider enrollment information, previous review histories, approved Treatment/Service authorization requests (TAR/SAR) and medical records. Other Department related resources such as provider business and professional licenses, Franchise Tax Board (FTB) reports also utilized.

A&I has three branches that conduct reviews using various methodologies to ensure program integrity and the validity of claims for reimbursement:

The A&I Medical Review Branch (MRB) performs essential medical reviews of non-institutional providers. Providers may also be subject to a more comprehensive review on a weekly basis known as a pre-checkwrite review. This review is based on a set of criteria, such as irregular billing patterns, designed to identify potential fraud or abuse. Providers selected for this more comprehensive review will receive an on-site visit by A&I staff. Many of these reviews result in program removal, monetary penalties, or less intrusive sanctions and utilization controls.

MRB also conducts Medi-Cal provider anti-fraud activities that include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program.

MRB staff work closely with claims processors and data storage providers in data mining and extracting processes as well as the performance of the annual Medi-Cal Payment Error Study.

The A&I Financial Audits Branch performs cost settlement and rate setting audits of institutional providers, i.e. hospitals, nursing facilities, and certain clinics.

The A&I Investigations Branch (IB) conducts investigations of suspected Medi-Cal beneficiary fraud as well as preliminary investigations of provider fraud. A&I IB is also responsible for coordinating provider fraud referrals to the California State Department of Justice (DOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to the DOJ via the A&I IB.

A&I, IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. A&I IB serves as DHCS principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

Additionally, in the event CDA or DHCS discover evidence of fraud that may require further investigation, CDA notifies DHCS of the potential issue and/or DHCS refers the issue to DHCS A&I for further review and action.

Additional State Financial Audits

Fiscal and compliance audits are conducted by the California Department of Aging (CDA) Audits and Risk Management Branch to provide reasonable assurance that payments to sites made for services performed under the Home and Community Based Services (HCBS) Waiver are in accordance with federal and state requirements. MSSP sites are subject to an audit of HCBS services within three years of the final closeout report of any given state fiscal year which they operated.

During a CDA fiscal and compliance audit, a statistically valid sample of claims will be reconciled with payments received through Remittance Advice Detail forms and the MSSP site's accounting records. In addition, the total payments through Remittance Advice Detail forms is reconciled against the MSSP site's accounting records for each state fiscal year which they operated.

To ensure compliance with applicable laws, regulations, grants, and contract requirements, every three years the CDA Audits and Risk Management Branch conducts an audit of the MSSP site's internal controls, financial reporting and compliance requirements. Specifically, the objectives are to determine whether the site:

- *Developed annual Final Accounting Reconciliations that fairly present the financial operations of the MSSP;*
- *Maintained adequate internal controls to ensure that care management expenses reported to the Medi-Cal program were accurate and allowable;*
- *Maintained adequate internal controls for the procurement and utilization of Waiver Services to ensure Waiver Services claimed to the Medi-Cal program were accurate and allowable; and,*
- *Maintained adequate internal controls to ensure compliance with applicable laws, regulations, and contract requirements.*

CDA Audit staff conduct audits in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office, by the Comptroller General of the United States, Government Auditing Standards.

The CDA Audits and Risk Management Branch requires that the MSSP sites that expend $750,000 or more in federal funds have an independent single audit, as required in the CDA Standard Agreement, Exhibit D, Article X. Single audit findings are reported to CDA's MSSP Bureau. All fiscal and compliance audit reports completed by CDA are forwarded to DHCS for review. Appeals to audit findings are made in accordance with the California Code of Regulations, Title 22, Sections 51015-51047.

Electronic Visit Verification (EVV) Compliance
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:
The percentage of FFS claims and CCI encounters that were submitted in accordance with the Waiver Participant's authorized MSSP services. Numerator: Number of records that demonstrated that MSSP claims and encounters were submitted according to authorized MSSP services. Denominator: Total number of records 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%, with a margin of error +/- 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:
The percentage 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:*

Performance Measure:
The percentage of FFS claims and CCI encounters that were coded as specified in the Waiver. Numerator: Number of records that demonstrated FFS claims and CCI

encounters were coded as specified in the Waiver. Denominator: Total number of records reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
CAMMIS

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%, with a margin of error +/- 5%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *N/A*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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:
The percentage of records that utilized approved reimbursement rates. Numerator: Number of records that utilized approved reimbursement rates. Denominator: Total number of records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample***

		Confidence Interval = *95%, with a margin of error +/- 5%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the*

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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.*

Upon discovery that claims were not coded and paid for with the methodology defined in the Waiver, the State will contact the site to:
- Review the data
- Determine the reason for non-compliance
- Develop Corrective Action Plan and timeline if appropriate

The State will follow up to determine if the Corrective Action Plan was completed with successful outcome and monitor the change(s) for continuing compliance by utilizing case notes and other tools.

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).*

For Waiver Years 1 and 2, the state had Fee-For-Service (FFS) and Managed Care rate settings.

Fee-For-Service

MSSP's total annual funding, as established through the annual state budget process is $49,721,605 for WY1-WY2, $56,404,036 for WY3, and $63,950,640 for WY4-WY5. This equates to $5,356 per MSSP Waiver Participant slot annually. For WY1-WY2, MSSP utilized 9,283 Waiver Participant slots to serve the 11,370 potential Waiver Participants statewide on an annual basis. For WY3, Waiver Participant slots increased to 10,531 to serve the 11,940 potential Waiver Participants statewide on an annual basis. For WY4-WY5, Waiver Participant slots increased to 11,940 to serve the 13,373 potential Waiver Participants statewide on an annual basis (The difference between the two numbers represents Waiver Participant turnover during the year).

Each MSSP site receives an annual total budget based on the number of its participant slots times the per participant slot funding. Each site then develops a detailed budget based on prior experience and expected changes. These individual annual site budgets are submitted to CDA for review and approval.

The approved site budget is divided into three categories: Care Management (CM), Care Management Support (CMS) (these two areas are combined to become the Waiver Service Care Management) and Waiver Services, which is composed of all the other services that can be provided under the Waiver.

The CM category represents the costs for the CM staffing (NCMs, SWCMs, etc.). CM support represents the associated costs to support CM such as office space and travel costs (e.g. administrative costs). Rates are developed for CM and CM support by dividing the number of months and participant slots into the total anticipated costs. Sites then submit claims or encounters for all three budget categories through CA-MMIS during the year. Annual closeouts are submitted to CDA for review and approval. The closeouts are also audited by CDA auditors to assure that the claims or encounters reflect only actual and true costs. Effective July 1, 2019, a one-time appropriation spread over a three-year period will allow for a rate increase for care management and care management support services, which are billed separately from other Waiver Services. Effective July 1, 2022 the rate increase was made permanent.

Waiver Services are the services purchased for the participants by the MSSP sites from local service vendors. MSSP sites negotiate these rates locally based on community norms and pass those actual costs by reporting those same amounts through CA-MMIS. The individual MSSP sites negotiate Waiver Service rates with an array of vendors, which is verified during the Utilization Review process. For each Waiver Service, a maximum allowable rate is set, submitted in writing and approved by CDA, based on historically negotiated rates. Rates may be negotiated higher than the maximum allowable; however, CDA must approve these increases to the max rate on a case-by-case basis. The state reviews the negotiated fee-for-service rates on an annual basis and discusses any concerns with the MSSP site. The payment rates are available to Waiver Participants upon request. Additionally, CDA monitors average cost per unit by MSSP site for wide variances between sites serving a similar demographic.

Managed Care (In effect until December 31, 2021. Effective January 1, 2022 all CCI MSSP sites will be carved out of the 1115 demonstration.)

The Per Member Per Month rate equals 1/12 of the annual budgeted Waiver Slot allotment. WY1-WY3: $5,356/12 = $446.35.

All MSSP claims or encounters are subject to the CA-MMIS edits and audits. In order to capture service data and associated costs for each Waiver Participant, MSSP Providers will submit FFS claims, or encounter data (zero-based/ non-reimbursed claims) to CA-MMIS. CA-MMIS is designed to reimburse FFS claims, and capture encounter data for reporting purposes. In addition, expenditures are monitored on an ongoing basis by CDA staff. Each MSSP site's expenditures are capped in CAMMIS with the site's total budget so that no site can spend over their total budgeted amount. Each MSSP site's fiscal system is audited for each year by CDA auditors to assure that the claims or encounters submitted to CAMMIS reflect actual and true costs incurred in MSSP operations.

MSSP sites will coordinate care planning and service delivery with the Managed Care Plan for the Plan covered benefit.

Waiver Participants have the opportunity to review the rate methodology identified in the Waiver application and provide input during the public comment period. In regards to the July 1, 2019 rate increase, the MSSP Site Association (MSA) informed its stakeholder groups, and individual MSSP sites encouraged their stakeholders to attend Senate and Assembly Budget hearings. During these hearings, there was an open forum to allow for public comment. Participants, providers, advocacy groups, and the community at large had the opportunity to comment on the proposal. MSA and stakeholders also had opportunities to provide input during hearings related to the decision to make the rate increase permanent effective July 1, 2022.

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:*

Fee-For-Service

MSSP claims flow directly from the MSSP sites to CA-MMIS for adjudication and payment. The MSSP Care Manager is responsible for prior authorization of all MSSP Waiver Services and verifies that the requested services are in accordance with the MSSP participant's care plan (CP). FFS Claims are paid after the service is rendered.

MSSP Waiver providers submit claims to the FI for services rendered using an 837i claim form. These claims are subject to all established requirements for processing directly through the CA-MMIS system. The FI adjudicates claims for services.

Claims Adjudication – One of four possible actions:
1. *Paid claim (FFS)*
2. *Denied claim (FFS)*
3. *Suspended claim (FI staff perform further research) (FFS)*
4. *Additional information is requested (a Resubmission Transmittal Document (RTD) is sent to the provider requesting additional information) (FFS)*

Claims passing all edits and audits are adjudicated daily. The FI forwards a FFS payment tape weekly to the State Controller's office for payment and the provider is notified through a Remittance Advice Detail form.

Managed Care (In effect until December 31, 2021. Effective January 1, 2022 all CCI MSSP sites will be carved out of the 1115 demonstration.)

MSSP Sites will submit a Claim Processing Form monthly to the Managed Care Plan. The Plan will verify the Waiver Participant's Plan status and send payment to MSSP Sites.

MSSP encounter data (zero-based/non-reimbursed claims) flow directly from the MSSP sites to CA-MMIS for adjudication. The MSSP Care Manager is responsible for prior authorization of all MSSP Waiver services and verifies that the requested services are in accordance with the MSSP participant's care plan (CP).

MSSP Waiver providers submit encounter data to the FI for services rendered using an 837i claim form. These claims are subject to all established requirements for processing directly through the CA-MMIS system. The FI adjudicates encounter data for services.

Encounter Adjudication – One of four possible actions:
1. *Approved encounter*
2. *Denied encounter*
3. *Suspended encounter*
4. *Additional information requested*

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:*

Fee-For-Service (FFS)

MSSP site care managers review expenditure documents with the site fiscal officer to assure that services are included in the approved service plan, and to verify the accuracy of the services utilized, amount, and date(s) services were provided.

The State's Fiscal Intermediary (FI) performs routine and ad hoc claim reviews (edits and audits) to assure that FFS payment is only made when the individual was eligible for the Medicaid Waiver.

CDA staff, during Utilization Reviews, review a statistically valid sampling of MSSP site and Waiver Participant records to assure adequate documentation exists to validate that provider expenditures were accurately made.

MSSP site fiscal systems are audited for each year by CDA auditors to assure that the expenditures submitted to CA-MMIS reflect actual and true costs incurred in MSSP operations. Claims or encounters that are not valid or accurate, based upon an audit finding, will be recovered by the State.

In order to recoup inappropriate billings from providers, CDA generates a Transmittal Memo and submits it to DHCS instructing the FI to recover the inappropriate billings. DHCS issues a demand letter to the MSSP site with the amount owed. If the site does not pay the amount owed within 60 days, the FI will withhold future payments until the amount is recovered. After inappropriate billings are identified and returned, DHCS Accounting reconciles the FFP calculation on a quarterly basis on the CMS 64 report. Since all claims route through the FI, the Quarterly report includes the reconciled reimbursements and recoupments at a point in time.

Managed Care (In effect until December 31, 2021. Effective January 1, 2022 all CCI MSSP sites will be carved out of the 1115 demonstration.)

MSSP site care managers review expenditure documents with the site fiscal officer to assure that services are included in the approved service plan, and to verify the accuracy of the services utilized, amount, and date(s) services were provided.

The MSSP Site and Managed Care Plan staff perform routine eligibility reviews (the first through fifth of each month) through the Medi-Cal Eligibility Data System (MEDS) to assure that a capitated payment is made only when the individual is an MSSP Waiver Participant and a Plan Member.

MSSP Sites submit encounters through CA-MMIS and to the Managed Care Plan for State and Plan oversight and review.

CDA staff, during utilization reviews, review a sampling of MSSP site and participant records to assure adequate documentation exists to validate that provider expenditures were accurately made and reported.

MSSP site fiscal systems are audited for each fiscal year by CDA auditors to assure that the expenditures reported for managed care enrollees reflect actual and true costs incurred in MSSP operations.

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:

MSSP, by law, contracts with governmental or nonprofit agencies to provide MSSP services.

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 A MSSP Site

MSSP sites must be governmental or non-profit agencies. The MSSP sites are procured through the State contracting process which involves a Request for Proposal(RFP).

Provider Number

After the RFP process each agency must obtain an MSSP Medi-Cal provider number through the DHCS Provider Enrollment Branch, Payment Systems Division for processing.

Disclosure / Program Integrity

Federal regulations require providers of Medicaid programs to ensure program integrity by requiring providers to disclose certain information. Medi-Cal satisfies these federal regulations for disclosure and deters fraud and abuse by requiring providers to complete DHCS 6207, the Medi-Cal Disclosure Statement form. The DHCS 6207 is submitted to the Payment Systems Division, DHCS for processing.

Provider Qualifications / Requirements

MSSP sites must be governmental or non-profit agencies which are procured through the State contracting process which involves an RFP (request for proposal).

Informing New Enrollees

Once an individual is determined eligible to enroll in the MSSP, a qualified care manager describes the MSSP's 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 MSSP. The qualified care manager answers any questions the interested individual/applicant may have.

Enrollment and Selections

In order to participate in the MSSP, an applicant must sign the Application for the Multipurpose Senior Services Program form, acknowledging their rights, grievance procedures, and the right to a State Medi-Cal Fair Hearing.

MSSP Site Requirements

The State requires MSSP sites to have a formal contracting process to select qualified vendors for all Waiver Services and to monitor the provision of services by the vendors.

Monitoring of MSSP vendors

CDA performs utilization reviews (URs) to ensure that the site contracting process meets CDA's requirements, that the vendors are qualified and that the services are provided in accordance with the Waiver Participant's plan of care.

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:*

Do not complete this item.

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: 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	4373.05	20933.00	25306.05	41704.00	3866.00	45570.00	20263.95
2	4373.05	21561.00	25934.05	42955.00	3892.00	46847.00	20912.95
3	4723.96	22208.00	26931.96	43728.00	4101.00	47829.00	20897.04
4	4782.07	22874.00	27656.07	45040.00	4224.00	49264.00	21607.93
5	4782.07	23560.00	28342.07	46391.00	4351.00	50742.00	22399.93

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:
		Nursing Facility
Year 1	11370	11370
Year 2	11370	11370
Year 3	11940	11940
Year 4	13373	13373
Year 5	13373	13373

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 Waiver Year 2016-2017 CMS 372 data compiled by DHCS' Integrated Systems of Care Division.

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:*

Waiver Year Five has been updated to reflect new Waiver Service unit types in alignment with the changes made during the Code Conversion project, which replaces local billing codes with HIPAA-compliant Healthcare Common Procedure Coding System (HCPCS) national codes effective 12/31/23. Also during Waiver Year Five, effective 12/31/23, two Waiver Service categories for Community Transition Services (Moving and Housing/Utility Set-up) have been combined into one Waiver Service category, billed under the one available HCPCS code.

Estimated Number of Users:
The estimated number of users is 11,370 in Waiver Year One; 11,370 in Waiver Year Two; 11,940 in Waiver Year Three; 13,373 in Waiver Year Four; and 13,373 in Waiver Year Five. For W1-W2, the estimated number of users was extrapolated from the actual numbers provided on the CMS 372 Report for Waiver Years 2012-13, 2013-14, 2014-15, 2015-16 and 2016-17. For WY3-WY5, the estimated number of users was extrapolated from the actual numbers provided on the CMS 372 Report for Waiver Year 2019-20, factoring in the increase to participant slots effective January 1, 2022.

Units/User:
The total unit count for WY1-WY2 was extrapolated from the actual numbers provided in the CMS 372 Report for Waiver Year 2016-2017. The total unit count for WY3-WY4 was extrapolated from the actual numbers provided in the CMS 372 Report for Waiver Year 2019-20. The total unit count for WY5 was extrapolated from the actual numbers provided in the CMS 372 Report for Waiver Years 2019-20 and 2020-21. Adjustments were made based on changes to unit types. For example, numbers previously provided in an hourly unit type were converted to a 15-minute unit type by multiplying by four.

Cost/Unit:
The cost per unit count for WY1-WY2 was extrapolated from the actual numbers provided in the CMS 372 Report for Waiver Year 2016-2017. The cost per unit count for WY3-WY4 was extrapolated from the actual numbers provided in the CMS 372 Report for Waiver Year 2019-20. The total cost per unit count for WY5 was extrapolated from the actual numbers provided in the CMS 372 Report for Waiver Years 2019-20 and 2020-21. Adjustments were made based on changes to unit types. For example, numbers previously provided in an hourly unit type were converted to a 15-minute unit type by multiplying by four.

Total Cost:
The total cost was calculated by multiplying the number of users by the units per user and by the cost per unit.

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' equals the average per capita annual costs for all other Medicaid services (ancillary) to MSSP recipients (excluding MSSP costs). These estimates are based on actual costs from the approved CMS 372 for WY 2016-2017 projected out with a 3% growth factor over the horizon of the Waiver. The 3 percent growth rate is based on an overall average percentage change of 2.7% for D', G and G' reported on the CMS 372 during the Waiver years 2012-13, 2013-14, 2014-15, 2015-16 and 2016-17.

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 equals the institutional costs for non-Waiver beneficiaries (peer group costs). These estimates are based on actual costs from the approved CMS 372 for WY 2016-2017 projected out with a 3% growth factor over the horizon of the waiver. The 3 percent growth rate is based on an overall average percentage change of 2.7% for D', G and G' reported on the CMS 372 during the Waiver years 2012-13, 2013-14, 2014-15, 2015-16 and 2016-17.

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' equals the ancillary costs for the non-Waiver beneficiaries in G above (peer group costs). These estimates are based on actual costs from the approved CMS 372 for WY 2016-2017 projected out with a 3% growth factor over the horizon of the Waiver. The 3 percent growth rate is based on an overall average percentage change of 2.7% for D', G and G' reported on the CMS 372 during the Waiver years 2012-13, 2013-14, 2014-15, 2015-16 and 2016-17.

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	
Care Management	
Respite Care	
Supplemental Homemaker Services	
Supplemental Personal Care	
Adult Day Care	
Assistive Technology	
Communication: Device	
Communication: Translation/Interpretation	
Community Transition Services (Combined)	
Community Transition Services: Housing & Utility Set-up	
Community Transition Services: Moving Services	
Consultative Clinical Services	
Minor Home Repairs and Maintenance	
Money Management	
Non-Medical Home Equipment	
Nutritional Services	
Social Support	
Supplemental Protective Supervision	
Therapeutic Counseling	
Therapeutic Services	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a),

Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Management Total:							**45436012.86**
Care Management - Site (Month)	☐	Month	6852	9.00	337.62	**20820350.16**	
Deinstitutuional CM (OTO)	☐	OTO	7	1.00	3560.00	**24920.00**	
MSSP Managed Care	☒	Month	5668	9.72	446.35	**24590742.70**	
Deinstitutional CM (Month)	☐	Month	0	0.00	3560.00	**0.00**	
Respite Care Total:							**366400.00**
Respite Out of Home (Day)	☐	Day	30	8.00	175.00	**42000.00**	
Respite In-Home (Day)	☐	Day	120	15.00	125.00	**225000.00**	
Respite In-Home (Hour)	☐	Hour	93	25.00	40.00	**93000.00**	
Respite Out of Home (Hour)	☐	Hour	8	20.00	40.00	**6400.00**	
Respite Out of Home (Diem)	☐	Diem	0	0.00	175.00	**0.00**	
Respite Out of Home (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Respite In-Home (Diem)	☐	Diem	0	0.00	141.00	**0.00**	
Respite In-Home (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Supplemental Homemaker Services Total:							**254040.00**
Supplemental Homemaker (Hour)	☐	Hour	380	33.00	20.00	**250800.00**	
Supplemental Homemaker (Day)	☐	Day	35	2.00	40.00	**2800.00**	
Supplemental Homemaker (Event)	☐	Event	11	1.00	40.00	**440.00**	
Supplemental Homemaker (Diem)	☐	Diem	0	0.00	168.00	**0.00**	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplemental Homemaker (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Supplemental Personal Care Total:							679859.53
Supplemental Personal Care (Day)	☐	Day	53	2.00	95.00	10070.00	
Supplemental Personal Care (Visit)	☐	Visit	151	1.00	95.03	14349.53	
Supplemental Personal Care (Hour)	☐	Hour	2731	8.00	30.00	655440.00	
Supplemental Personal Care (Diem)	☐	Diem	0	0.00	286.00	0.00	
Supplemental Personal Care (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Adult Day Care Total:							110625.00
Adult Day Care (Hour)	☐	Hour	10	80.00	30.00	24000.00	
Adult Day Care (Day)	☐	Day	45	35.00	55.00	86625.00	
Adult Day Care (15 min)	☐	15 minutes	0	0.00	8.00	0.00	
Adult Day Care (Diem)	☐	Diem	0	0.00	90.00	0.00	
Assistive Technology Total:							113715.00
Assistive Technology (Event)	☐	Event	361	3.00	105.00	113715.00	
Safety equipment device or accessory (Each)	☐	Each	0	0.00	127.00	0.00	
Electronic medication compliance device (Each)	☐	Each	0	0.00	262.00	0.00	
Communication: Device Total:							968435.00
Communication-Device (Event)	☐	Event	751	1.00	45.00	33795.00	
Communication-Device (Month)	☐	Month	3338	8.00	35.00	934640.00	
ERS device (Purchase)	☐	Device	0	0.00	50.00	0.00	
ERS service fee (Month)	☐	Month	0	0.00	50.00	0.00	
Monitoring feature/device (Each)	☐	Each	0	0.00	100.00	0.00	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alert or alarm device (Each)	☐	Each	0	0.00	80.00	0.00	
Communication: Translation/Interpretation Total:							13280.00
Communication - Translation (Hour)	☐	Hour	83	4.00	40.00	13280.00	
Communication - Translation (15 min)	☐	15 minutes	0	0.00	13.00	0.00	
Community Transition Services (Combined) Total:							0.00
Moving, Housing & Utility Set-up (Service)	☐	Service	0	0.00	700.00	0.00	
Community Transition Services: Housing & Utility Set-up Total:							23100.00
Housing & Utility Set-up (Event)	☐	Event	33	1.00	700.00	23100.00	
Community Transition Services: Moving Services Total:							20000.00
Moving Services (Event)	☐	Event	50	1.00	400.00	20000.00	
Consultative Clinical Services Total:							130250.00
Consultative Clinical Services (Visit)	☐	Visit	78	3.00	100.00	23400.00	
Consultative Clinical Services (Hour)	☐	Hour	139	13.00	50.00	90350.00	
Consultative Clinical Services (Day)	☐	Day	66	2.00	125.00	16500.00	
Nutritional counseling, dietician (Visit)	☐	Visit	0	0.00	150.00	0.00	
Social work visit, in the home (15 min)	☐	15 minutes	0	0.00	22.00	0.00	
Social work visit, in the home (Diem)	☐	Diem	0	0.00	150.00	0.00	
Medication training and support (15 min)	☐	15 minutes	0	0.00	22.00	0.00	
Waiver Services NOS: Legal/paralegal services (Hour)	☐	Hour	0	0.00	90.00	0.00	
Telemonitoring of patient in their home (Month)	☐	Month	0	0.00	150.00	0.00	
Minor Home Repairs and Maintenance Total:							511200.00

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
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Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minor Home Repair / Maintenance (Event)	☐	Event	1420	2.00	180.00	511200.00	
Minor Home Repair / Maintenance (Service)	☐	Service	0	0.00	400.00	0.00	
Money Management Total:							22500.00
Money Management (Visit)	☐	Visit	18	5.00	50.00	4500.00	
Money Management (Hour)	☐	Hour	40	15.00	30.00	18000.00	
Money Management (15 min)	☐	15 minutes	0	0.00	8.00	0.00	
Non-Medical Home Equipment Total:							341145.00
Non-medical Home Equipment (Event)	☐	Event	1083	3.00	105.00	341145.00	
Misc. therapeutic items and supplies (Each)	☐	Each	0	0.00	125.00	0.00	
Personal care items (Each)	☐	Each	0	0.00	125.00	0.00	
Exercise equipment (Each)	☐	Each	0	0.00	99.01	0.00	
Nutritional Services Total:							211628.00
Oral Nutritional Supplements (Event)	☐	Event	200	2.00	50.00	20000.00	
Meals - Home Delivered (Meal)	☐	Home Delivered Meal	321	49.00	12.00	188748.00	
Meals - Congregate (Meal)	☐	Congregate Meal	40	12.00	6.00	2880.00	
Oral Nutritional Supplements (Each)	☐	Each	0	0.00	62.00	0.00	
Meals - Congregate (Diem)	☐	Diem	0	0.00	10.00	0.00	
Social Support Total:							60000.00
Social Support (Hour)	☐	Hour	85	25.00	20.00	42500.00	
Social Support (Day)	☐	Day	5	5.00	100.00	2500.00	
Social Support (Month)	☐	Month	15	8.00	125.00	15000.00	
Social Support (15 min)	☐	15 minutes	0	0.00	7.00	0.00	
Social Support (Diem)	☐					0.00	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
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Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Diem	0	0.00	100.00		
Supplemental Protective Supervision Total:							**5740.00**
Supplemental Protective Supervision (Day)	☐	Day	14	1.00	150.00	**2100.00**	
Supplemental Protective Supervision (Hour)	☐	Hour	7	13.00	40.00	**3640.00**	
Supplemental Protective Supervision (Diem)	☐	Diem	0	0.00	150.00	**0.00**	
Supplemental Protective Supervision (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Therapeutic Counseling Total:							**13500.00**
Therapeutic Counseling (Hour)	☐	Hour	20	9.00	75.00	**13500.00**	
Therapeutic Counseling (15 min)	☐	15 minutes	0	0.00	21.00	**0.00**	
Therapeutic Services Total:							**41250.00**
Therapeutic Services (Hour)	☐	Hour	50	12.00	50.00	**30000.00**	
Therapeutic Services (Day)	☐	Day	25	2.00	125.00	**6250.00**	
Therapeutic Services (Visit)	☐	Visit	25	2.00	100.00	**5000.00**	
Physical therapy, in the home (15 min)	☐	15 minutes	0	0.00	17.00	**0.00**	
Physical therapy, in the home (Diem)	☐	Diem	0	0.00	125.00	**0.00**	
Physical or manipulative therapy (Visit)	☐	Visit	0	0.00	125.00	**0.00**	
Routine foot care, preventative maintenance (Visit)	☐	Visit	0	0.00	125.00	**0.00**	
Activity therapy (15 min)	☐	15 minutes	0	0.00	16.00	**0.00**	
Transportation Total:							**398925.00**
Transportation (Hour)	☐	Hour	345	23.00	15.00	**119025.00**	
Transportation (One-Way-Trip)	☐	One-Way-Trip	933	20.00	15.00	**279900.00**	
Transportation- One-Way-Trip (Each)	☐					**0.00**	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Each	0	0.00	37.00		

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Management Total:							**45436012.86**
Care Management - Site (Month)	☐	Month	6852	9.00	337.62	**20820350.16**	
Deinstitutuional CM (OTO)	☐	OTO	7	1.00	3560.00	**24920.00**	
MSSP Managed Care	☒	Month	5668	9.72	446.35	**24590742.70**	
Deinstitutional CM (Month)	☐	Month	0	0.00	3560.00	**0.00**	
Respite Care Total:							**366400.00**
Respite Out of Home (Day)	☐	Day	30	8.00	175.00	**42000.00**	
Respite In-Home (Day)	☐	Day	120	15.00	125.00	**225000.00**	
Respite In-Home (Hour)	☐	Hour	93	25.00	40.00	**93000.00**	
Respite Out of Home (Hour)	☐	Hour	8	20.00	40.00	**6400.00**	
Respite Out of Home (Diem)	☐	Diem				**0.00**	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			0	0.00	175.00		
Respite Out of Home (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Respite In-Home (Diem)	☐	Diem	0	0.00	141.00	0.00	
Respite In-Home (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Supplemental Homemaker Services Total:							254040.00
Supplemental Homemaker (Hour)	☐	Hour	380	33.00	20.00	250800.00	
Supplemental Homemaker (Day)	☐	Day	35	2.00	40.00	2800.00	
Supplemental Homemaker (Event)	☐	Event	11	1.00	40.00	440.00	
Supplemental Homemaker (Diem)	☐	Diem	0	0.00	168.00	0.00	
Supplemental Homemaker (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Supplemental Personal Care Total:							679859.53
Supplemental Personal Care (Day)	☐	Day	53	2.00	95.00	10070.00	
Supplemental Personal Care (Visit)	☐	Visit	151	1.00	95.03	14349.53	
Supplemental Personal Care (Hour)	☐	Hour	2731	8.00	30.00	655440.00	
Supplemental Personal Care (Diem)	☐	Diem	0	0.00	286.00	0.00	
Supplemental Personal Care (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Adult Day Care Total:							110625.00
Adult Day Care (Hour)	☐	Hour	10	80.00	30.00	24000.00	
Adult Day Care (Day)	☐	Day	45	35.00	55.00	86625.00	
Adult Day Care (15 min)	☐	15 minutes	0	0.00	8.00	0.00	
Adult Day Care (Diem)	☐	Diem	0	0.00	90.00	0.00	
Assistive Technology Total:							113715.00
Assistive Technology	☐					113715.00	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(Event)		Event	361	3.00	105.00		
Safety equipment device or accessory (Each)	☐	Each	0	0.00	127.00	0.00	
Electronic medication compliance device (Each)	☐	Each	0	0.00	262.00	0.00	
Communication: Device Total:							968435.00
Communication-Device (Event)	☐	Event	751	1.00	45.00	33795.00	
Communication-Device (Month)	☐	Month	3338	8.00	35.00	934640.00	
ERS device (Purchase)	☐	Device	0	0.00	50.00	0.00	
ERS service fee (Month)	☐	Month	0	0.00	50.00	0.00	
Monitoring feature/device (Each)	☐	Each	0	0.00	100.00	0.00	
Alert or alarm device (Each)	☐	Each	0	0.00	80.00	0.00	
Communication: Translation/Interpretation Total:							13280.00
Communication - Translation (Hour)	☐	Hour	83	4.00	40.00	13280.00	
Communication - Translation (15 min)	☐	15 minutes	0	0.00	13.00	0.00	
Community Transition Services (Combined) Total:							0.00
Moving, Housing & Utility Set-up (Service)	☐	Service	0	0.00	700.00	0.00	
Community Transition Services: Housing & Utility Set-up Total:							23100.00
Housing & Utility Set-up (Event)	☐	Event	33	1.00	700.00	23100.00	
Community Transition Services: Moving Services Total:							20000.00
Moving Services (Event)	☐	Event	50	1.00	400.00	20000.00	
Consultative Clinical Services Total:							130250.00
Consultative Clinical Services (Visit)	☐	Visit	78	3.00	100.00	23400.00	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical Services (Hour)	☐	Hour	139	13.00	50.00	**90350.00**	
Consultative Clinical Services (Day)	☐	Day	66	2.00	125.00	**16500.00**	
Nutritional counseling, dietician (Visit)	☐	Visit	0	0.00	150.00	**0.00**	
Social work visit, in the home (15 min)	☐	15 minutes	0	0.00	22.00	**0.00**	
Social work visit, in the home (Diem)	☐	Diem	0	0.00	150.00	**0.00**	
Medication training and support (15 min)	☐	15 minutes	0	0.00	22.00	**0.00**	
Waiver Services NOS: Legal/paralegal services (Hour)	☐	Hour	0	0.00	90.00	**0.00**	
Telemonitoring of patient in their home (Month)	☐	Month	0	0.00	150.00	**0.00**	
Minor Home Repairs and Maintenance Total:							**511200.00**
Minor Home Repair / Maintenance (Event)	☐	Event	1420	2.00	180.00	**511200.00**	
Minor Home Repair / Maintenance (Service)	☐	Service	0	0.00	400.00	**0.00**	
Money Management Total:							**22500.00**
Money Management (Visit)	☐	Visit	18	5.00	50.00	**4500.00**	
Money Management (Hour)	☐	Hour	40	15.00	30.00	**18000.00**	
Money Management (15 min)	☐	15 minutes	0	0.00	8.00	**0.00**	
Non-Medical Home Equipment Total:							**341145.00**
Non-medical Home Equipment (Event)	☐	Event	1083	3.00	105.00	**341145.00**	
Misc. therapeutic items and supplies (Each)	☐	Each	0	0.00	125.00	**0.00**	
Personal care items (Each)	☐	Each	0	0.00	125.00	**0.00**	
Exercise equipment (Each)	☐	Each	0	0.00	99.01	**0.00**	
Nutritional Services Total:							**211628.00**
Oral Nutritional Supplements (Event)	☐	Event	200	2.00	50.00	**20000.00**	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	*24590742.70*
Total: Services not included in capitation:	*25130862.69*
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	*2162.77*
Services not included in capitation:	*2210.28*
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals - Home Delivered (Meal)	☐	Home Delivered Meal	321	49.00	12.00	188748.00	
Meals - Congregate (Meal)	☐	Congregate Meal	40	12.00	6.00	2880.00	
Oral Nutritional Supplements (Each)	☐	Each	0	0.00	62.00	0.00	
Meals - Congregate (Diem)	☐	Diem	0	0.00	10.00	0.00	
Social Support Total:							60000.00
Social Support (Hour)	☐	Hour	85	25.00	20.00	42500.00	
Social Support (Day)	☐	Day	5	5.00	100.00	2500.00	
Social Support (Month)	☐	Month	15	8.00	125.00	15000.00	
Social Support (15 min)	☐	15 minutes	0	0.00	7.00	0.00	
Social Support (Diem)	☐	Diem	0	0.00	100.00	0.00	
Supplemental Protective Supervision Total:							5740.00
Supplemental Protective Supervision (Day)	☐	Day	14	1.00	150.00	2100.00	
Supplemental Protective Supervision (Hour)	☐	Hour	7	13.00	40.00	3640.00	
Supplemental Protective Supervision (Diem)	☐	Diem	0	0.00	150.00	0.00	
Supplemental Protective Supervision (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Therapeutic Counseling Total:							13500.00
Therapeutic Counseling (Hour)	☐	Hour	20	9.00	75.00	13500.00	
Therapeutic Counseling (15 min)	☐	15 minutes	0	0.00	21.00	0.00	
Therapeutic Services Total:							41250.00
Therapeutic Services (Hour)	☐	Hour	50	12.00	50.00	30000.00	
Therapeutic Services (Day)	☐	Day	25	2.00	125.00	6250.00	
Therapeutic Services (Visit)	☐	Visit	25	2.00	100.00	5000.00	

GRAND TOTAL:	**49721605.39**
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	**11370**
Factor D (Divide total by number of participants):	**4373.05**
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical therapy, in the home (15 min)	☐	15 minutes	0	0.00	17.00	0.00	
Physical therapy, in the home (Diem)	☐	Diem	0	0.00	125.00	0.00	
Physical or manipulative therapy (Visit)	☐	Visit	0	0.00	125.00	0.00	
Routine foot care, preventative maintenance (Visit)	☐	Visit	0	0.00	125.00	0.00	
Activity therapy (15 min)	☐	15 minutes	0	0.00	16.00	0.00	
Transportation Total:							398925.00
Transportation (Hour)	☐	Hour	345	23.00	15.00	119025.00	
Transportation (One-Way-Trip)	☐	One-Way-Trip	933	20.00	15.00	279900.00	
Transportation- One-Way-Trip (Each)	☐	Each	0	0.00	37.00	0.00	

GRAND TOTAL:	49721605.39
Total: Services included in capitation:	24590742.70
Total: Services not included in capitation:	25130862.69
Total Estimated Unduplicated Participants:	11370
Factor D (Divide total by number of participants):	4373.05
Services included in capitation:	2162.77
Services not included in capitation:	2210.28
Average Length of Stay on the Waiver:	295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Management Total:							49259850.81
Care Management - Site (Month)	☐	Month	10210	9.72	372.22	36939559.46	

GRAND TOTAL:	56404035.81
Total: Services included in capitation:	12295371.35
Total: Services not included in capitation:	44108664.46
Total Estimated Unduplicated Participants:	11940
Factor D (Divide total by number of participants):	4723.96
Services included in capitation:	1029.76
Services not included in capitation:	3694.19
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Deinstitutuional CM (OTO)	☐	OTO	7	1.00	3560.00	**24920.00**	
MSSP Managed Care	☒	Month	2834	9.72	446.35	**12295371.35**	
Deinstitutional CM (Month)	☐	Month	0	0.00	3560.00	**0.00**	
Respite Care Total:							**512400.00**
Respite Out of Home (Day)	☐	Day	30	8.00	175.00	**42000.00**	
Respite In-Home (Day)	☐	Day	120	15.00	125.00	**225000.00**	
Respite In-Home (Hour)	☐	Hour	239	25.00	40.00	**239000.00**	
Respite Out of Home (Hour)	☐	Hour	8	20.00	40.00	**6400.00**	
Respite Out of Home (Diem)	☐	Diem	0	0.00	175.00	**0.00**	
Respite Out of Home (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Respite In-Home (Diem)	☐	Diem	0	0.00	141.00	**0.00**	
Respite In-Home (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Supplemental Homemaker Services Total:							**539100.00**
Supplemental Homemaker (Hour)	☐	Hour	380	33.00	40.00	**501600.00**	
Supplemental Homemaker (Day)	☐	Day	225	2.00	50.00	**22500.00**	
Supplemental Homemaker (Event)	☐	Event	300	1.00	50.00	**15000.00**	
Supplemental Homemaker (Diem)	☐	Diem	0	0.00	168.00	**0.00**	
Supplemental Homemaker (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Supplemental Personal Care Total:							**914865.00**
Supplemental Personal Care (Day)	☐	Day	53	2.00	95.00	**10070.00**	
Supplemental Personal Care (Visit)	☐	Visit	325	1.00	95.00	**30875.00**	
Supplemental Personal Care (Hour)	☐	Hour	2731	8.00	40.00	**873920.00**	

GRAND TOTAL:	***56404035.81***
Total: Services included in capitation:	*12295371.35*
Total: Services not included in capitation:	*44108664.46*
Total Estimated Unduplicated Participants:	***11940***
Factor D (Divide total by number of participants):	***4723.96***
Services included in capitation:	*1029.76*
Services not included in capitation:	*3694.19*
Average Length of Stay on the Waiver:	*295*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplemental Personal Care (Diem)	☐	Diem	0	0.00	286.00	0.00	
Supplemental Personal Care (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Adult Day Care Total:							118500.00
Adult Day Care (Hour)	☐	Hour	10	80.00	30.00	24000.00	
Adult Day Care (Day)	☐	Day	45	35.00	60.00	94500.00	
Adult Day Care (15 min)	☐	15 minutes	0	0.00	8.00	0.00	
Adult Day Care (Diem)	☐	Diem	0	0.00	90.00	0.00	
Assistive Technology Total:							113715.00
Assistive Technology (Event)	☐	Event	361	3.00	105.00	113715.00	
Safety equipment device or accessory (Each)	☐	Each	0	0.00	127.00	0.00	
Electronic medication compliance device (Each)	☐	Each	0	0.00	262.00	0.00	
Communication: Device Total:							1420010.00
Communication-Device (Event)	☐	Event	925	1.00	50.00	46250.00	
Communication-Device (Month)	☐	Month	4293	8.00	40.00	1373760.00	
ERS device (Purchase)	☐	Device	0	0.00	50.00	0.00	
ERS service fee (Month)	☐	Month	0	0.00	50.00	0.00	
Monitoring feature/device (Each)	☐	Each	0	0.00	100.00	0.00	
Alert or alarm device (Each)	☐	Each	0	0.00	80.00	0.00	
Communication: Translation/Interpretation Total:							22000.00
Communication - Translation (Hour)	☐	Hour	110	4.00	50.00	22000.00	
Communication - Translation (15 min)	☐	15 minutes	0	0.00	13.00	0.00	
Community Transition Services (Combined)							0.00

GRAND TOTAL:	**56404035.81**
Total: Services included in capitation:	12295371.35
Total: Services not included in capitation:	44108664.46
Total Estimated Unduplicated Participants:	**11940**
Factor D (Divide total by number of participants):	**4723.96**
Services included in capitation:	1029.76
Services not included in capitation:	3694.19
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Moving, Housing & Utility Set-up (Service)	☐	Service	0	0.00	700.00	0.00	
Community Transition Services: Housing & Utility Set-up Total:							23100.00
Housing & Utility Set-up (Event)	☐	Event	33	1.00	700.00	23100.00	
Community Transition Services: Moving Services Total:							20000.00
Moving Services (Event)	☐	Event	50	1.00	400.00	20000.00	
Consultative Clinical Services Total:							130250.00
Consultative Clinical Services (Visit)	☐	Visit	78	3.00	100.00	23400.00	
Consultative Clinical Services (Hour)	☐	Hour	139	13.00	50.00	90350.00	
Consultative Clinical Services (Day)	☐	Day	66	2.00	125.00	16500.00	
Nutritional counseling, dietician (Visit)	☐	Visit	0	0.00	150.00	0.00	
Social work visit, in the home (15 min)	☐	15 minutes	0	0.00	22.00	0.00	
Social work visit, in the home (Diem)	☐	Diem	0	0.00	150.00	0.00	
Medication training and support (15 min)	☐	15 minutes	0	0.00	22.00	0.00	
Waiver Services NOS: Legal/paralegal services (Hour)	☐	Hour	0	0.00	90.00	0.00	
Telemonitoring of patient in their home (Month)	☐	Month	0	0.00	150.00	0.00	
Minor Home Repairs and Maintenance Total:							511200.00
Minor Home Repair / Maintenance (Event)	☐	Event	1420	2.00	180.00	511200.00	
Minor Home Repair / Maintenance (Service)	☐	Service	0	0.00	400.00	0.00	
Money Management Total:							104250.00
Money Management (Visit)	☐	Visit	21	5.00	50.00	5250.00	
Money Management (Hour)	☐	Hour	165	20.00	30.00	99000.00	

GRAND TOTAL:	**56404035.81**
Total: Services included in capitation:	12295371.35
Total: Services not included in capitation:	44108664.46
Total Estimated Unduplicated Participants:	**11940**
Factor D (Divide total by number of participants):	**4723.96**
Services included in capitation:	1029.76
Services not included in capitation:	3694.19
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Money Management (15 min)	☐	15 minutes	0	0.00	8.00	0.00	
Non-Medical Home Equipment Total:							1550000.00
Non-medical Home Equipment (Event)	☐	Event	3100	4.00	125.00	1550000.00	
Misc. therapeutic items and supplies (Each)	☐	Each	0	0.00	125.00	0.00	
Personal care items (Each)	☐	Each	0	0.00	125.00	0.00	
Exercise equipment (Each)	☐	Each	0	0.00	99.01	0.00	
Nutritional Services Total:							431580.00
Oral Nutritional Supplements (Event)	☐	Event	561	4.00	50.00	112200.00	
Meals - Home Delivered (Meal)	☐	Home Delivered Meal	321	49.00	20.00	314580.00	
Meals - Congregate (Meal)	☐	Congregate Meal	40	12.00	10.00	4800.00	
Oral Nutritional Supplements (Each)	☐	Each	0	0.00	62.00	0.00	
Meals - Congregate (Diem)	☐	Diem	0	0.00	10.00	0.00	
Social Support Total:							137500.00
Social Support (Hour)	☐	Hour	160	25.00	20.00	80000.00	
Social Support (Day)	☐	Day	85	5.00	100.00	42500.00	
Social Support (Month)	☐	Month	15	8.00	125.00	15000.00	
Social Support (15 min)	☐	15 minutes	0	0.00	7.00	0.00	
Social Support (Diem)	☐	Diem	0	0.00	100.00	0.00	
Supplemental Protective Supervision Total:							5740.00
Supplemental Protective Supervision (Day)	☐	Day	14	1.00	150.00	2100.00	
Supplemental Protective Supervision (Hour)	☐	Hour	7	13.00	40.00	3640.00	
Supplemental Protective Supervision (Diem)	☐	Diem	0	0.00	150.00	0.00	

GRAND TOTAL:	**56404035.81**
Total: Services included in capitation:	12295371.35
Total: Services not included in capitation:	44108664.46
Total Estimated Unduplicated Participants:	**11940**
Factor D (Divide total by number of participants):	**4723.96**
Services included in capitation:	1029.76
Services not included in capitation:	3694.19
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplemental Protective Supervision (15 min)	☐	15 minutes	0	0.00	10.00	0.00	
Therapeutic Counseling Total:							13500.00
Therapeutic Counseling (Hour)	☐	Hour	20	9.00	75.00	13500.00	
Therapeutic Counseling (15 min)	☐	15 minutes	0	0.00	21.00	0.00	
Therapeutic Services Total:							84250.00
Therapeutic Services (Hour)	☐	Hour	80	12.00	50.00	48000.00	
Therapeutic Services (Day)	☐	Day	25	2.00	125.00	6250.00	
Therapeutic Services (Visit)	☐	Visit	120	2.00	125.00	30000.00	
Physical therapy, in the home (15 min)	☐	15 minutes	0	0.00	17.00	0.00	
Physical therapy, in the home (Diem)	☐	Diem	0	0.00	125.00	0.00	
Physical or manipulative therapy (Visit)	☐	Visit	0	0.00	125.00	0.00	
Routine foot care, preventative maintenance (Visit)	☐	Visit	0	0.00	125.00	0.00	
Activity therapy (15 min)	☐	15 minutes	0	0.00	16.00	0.00	
Transportation Total:							492225.00
Transportation (Hour)	☐	Hour	345	23.00	15.00	119025.00	
Transportation (One-Way-Trip)	☐	One-Way-Trip	933	20.00	20.00	373200.00	
Transportation- One-Way-Trip (Each)	☐	Each	0	0.00	37.00	0.00	

GRAND TOTAL:	**56404035.81**
Total: Services included in capitation:	12295371.35
Total: Services not included in capitation:	44108664.46
Total Estimated Unduplicated Participants:	**11940**
Factor D (Divide total by number of participants):	**4723.96**
Services included in capitation:	1029.76
Services not included in capitation:	3694.19
Average Length of Stay on the Waiver:	295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Management Total:							**49036596.12**
Care Management - Site (Month)	☐	Month	13373	9.72	377.00	**49004556.12**	
Deinstitutuional CM (OTO)	☐	OTO	9	1.00	3560.00	**32040.00**	
MSSP Managed Care	☒	Month	0	9.72	446.35	**0.00**	
Deinstitutional CM (Month)	☐	Month	0	0.00	3560.00	**0.00**	
Respite Care Total:							**577450.00**
Respite Out of Home (Day)	☐	Day	38	8.00	175.00	**53200.00**	
Respite In-Home (Day)	☐	Day	150	15.00	141.00	**317250.00**	
Respite In-Home (Hour)	☐	Hour	199	25.00	40.00	**199000.00**	
Respite Out of Home (Hour)	☐	Hour	10	20.00	40.00	**8000.00**	
Respite Out of Home (Diem)	☐	Diem	0	0.00	175.00	**0.00**	
Respite Out of Home (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Respite In-Home (Diem)	☐	Diem	0	0.00	141.00	**0.00**	
Respite In-Home (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Supplemental Homemaker Services Total:							**797541.00**
Supplemental Homemaker (Hour)	☐	Hour	475	36.00	40.00	**684000.00**	
Supplemental Homemaker (Day)	☐	Day	281	2.00	168.00	**94416.00**	
Supplemental Homemaker (Event)	☐	Event	375	1.00	51.00	**19125.00**	
Supplemental Homemaker (Diem)	☐	Diem	0	0.00	168.00	**0.00**	
Supplemental Homemaker (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Supplemental Personal							**3763442.00**

GRAND TOTAL:	**63950640.12**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	63950640.12
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Total:							
Supplemental Personal Care (Day)	☐	Day	66	2.00	286.00	**37752.00**	
Supplemental Personal Care (Visit)	☐	Visit	406	1.00	95.00	**38570.00**	
Supplemental Personal Care (Hour)	☐	Hour	3414	27.00	40.00	**3687120.00**	
Supplemental Personal Care (Diem)	☐	Diem	0	0.00	286.00	**0.00**	
Supplemental Personal Care (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Adult Day Care Total:							**207600.00**
Adult Day Care (Hour)	☐	Hour	13	80.00	30.00	**31200.00**	
Adult Day Care (Day)	☐	Day	56	35.00	90.00	**176400.00**	
Adult Day Care (15 min)	☐	15 minutes	0	0.00	8.00	**0.00**	
Adult Day Care (Diem)	☐	Diem	0	0.00	90.00	**0.00**	
Assistive Technology Total:							**171831.00**
Assistive Technology (Event)	☐	Event	451	3.00	127.00	**171831.00**	
Safety equipment device or accessory (Each)	☐	Each	0	0.00	127.00	**0.00**	
Electronic medication compliance device (Each)	☐	Each	0	0.00	262.00	**0.00**	
Communication: Device Total:							**2478400.00**
Communication-Device (Event)	☐	Event	1274	1.00	50.00	**63700.00**	
Communication-Device (Month)	☐	Month	5366	9.00	50.00	**2414700.00**	
ERS device (Purchase)	☐	Device	0	0.00	50.00	**0.00**	
ERS service fee (Month)	☐	Month	0	0.00	50.00	**0.00**	
Monitoring feature/device (Each)	☐	Each	0	0.00	100.00	**0.00**	
Alert or alarm device (Each)	☐	Each	0	0.00	80.00	**0.00**	
Communication:							**62100.00**

GRAND TOTAL:	**63950640.12**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	63950640.12
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Translation/Interpretation Total:							
Communication - Translation (Hour)	☐	Hour	138	9.00	50.00	**62100.00**	
Communication - Translation (15 min)	☐	15 minutes	0	0.00	13.00	**0.00**	
Community Transition Services (Combined) Total:							**0.00**
Moving, Housing & Utility Set-up (Service)	☐	Service	0	0.00	700.00	**0.00**	
Community Transition Services: Housing & Utility Set-up Total:							**28700.00**
Housing & Utility Set-up (Event)	☐	Event	41	1.00	700.00	**28700.00**	
Community Transition Services: Moving Services Total:							**44100.00**
Moving Services (Event)	☐	Event	63	1.00	700.00	**44100.00**	
Consultative Clinical Services Total:							**303900.00**
Consultative Clinical Services (Visit)	☐	Visit	98	3.00	150.00	**44100.00**	
Consultative Clinical Services (Hour)	☐	Hour	174	15.00	90.00	**234900.00**	
Consultative Clinical Services (Day)	☐	Day	83	2.00	150.00	**24900.00**	
Nutritional counseling, dietician (Visit)	☐	Visit	0	0.00	150.00	**0.00**	
Social work visit, in the home (15 min)	☐	15 minutes	0	0.00	22.00	**0.00**	
Social work visit, in the home (Diem)	☐	Diem	0	0.00	150.00	**0.00**	
Medication training and support (15 min)	☐	15 minutes	0	0.00	22.00	**0.00**	
Waiver Services NOS: Legal/paralegal services (Hour)	☐	Hour	0	0.00	90.00	**0.00**	
Telemonitoring of patient in their home (Month)	☐	Month	0	0.00	150.00	**0.00**	
Minor Home Repairs and Maintenance Total:							**1420000.00**
Minor Home Repair / Maintenance (Event)	☐	Event	1775	2.00	400.00	**1420000.00**	

GRAND TOTAL:	**63950640.12**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	63950640.12
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minor Home Repair / Maintenance (Service)	☐	Service	0	0.00	400.00	0.00	
Money Management Total:							130100.00
Money Management (Visit)	☐	Visit	26	5.00	50.00	6500.00	
Money Management (Hour)	☐	Hour	206	20.00	30.00	123600.00	
Money Management (15 min)	☐	15 minutes	0	0.00	8.00	0.00	
Non-Medical Home Equipment Total:							2421875.00
Non-medical Home Equipment (Event)	☐	Event	3875	5.00	125.00	2421875.00	
Misc. therapeutic items and supplies (Each)	☐	Each	0	0.00	125.00	0.00	
Personal care items (Each)	☐	Each	0	0.00	125.00	0.00	
Exercise equipment (Each)	☐	Each	0	0.00	98.82	0.00	
Nutritional Services Total:							928544.00
Oral Nutritional Supplements (Event)	☐	Event	701	12.00	62.00	521544.00	
Meals - Home Delivered (Meal)	☐	Home Delivered Meal	401	50.00	20.00	401000.00	
Meals - Congregate (Meal)	☐	Congregate Meal	50	12.00	10.00	6000.00	
Oral Nutritional Supplements (Each)	☐	Each	0	0.00	62.00	0.00	
Meals - Congregate (Diem)	☐	Diem	0	0.00	10.00	0.00	
Social Support Total:							214375.00
Social Support (Hour)	☐	Hour	200	25.00	28.00	140000.00	
Social Support (Day)	☐	Day	106	5.00	100.00	53000.00	
Social Support (Month)	☐	Month	19	9.00	125.00	21375.00	
Social Support (15 min)	☐	15 minutes	0	0.00	7.00	0.00	
Social Support (Diem)	☐	Diem	0	0.00	100.00	0.00	
Supplemental Protective							7380.00

GRAND TOTAL:	**63950640.12**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	63950640.12
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supervision Total:							
Supplemental Protective Supervision (Day)	☐	Day	18	1.00	150.00	**2700.00**	
Supplemental Protective Supervision (Hour)	☐	Hour	9	13.00	40.00	**4680.00**	
Supplemental Protective Supervision (Diem)	☐	Diem	0	0.00	150.00	**0.00**	
Supplemental Protective Supervision (15 min)	☐	15 minutes	0	0.00	10.00	**0.00**	
Therapeutic Counseling Total:							**21000.00**
Therapeutic Counseling (Hour)	☐	Hour	25	10.00	84.00	**21000.00**	
Therapeutic Counseling (15 min)	☐	15 minutes	0	0.00	21.00	**0.00**	
Therapeutic Services Total:							**124450.00**
Therapeutic Services (Hour)	☐	Hour	100	12.00	66.00	**79200.00**	
Therapeutic Services (Day)	☐	Day	31	2.00	125.00	**7750.00**	
Therapeutic Services (Visit)	☐	Visit	150	2.00	125.00	**37500.00**	
Physical therapy, in the home (15 min)	☐	15 minutes	0	0.00	17.00	**0.00**	
Physical therapy, in the home (Diem)	☐	Diem	0	0.00	125.00	**0.00**	
Physical or manipulative therapy (Visit)	☐	Visit	0	0.00	125.00	**0.00**	
Routine foot care, preventative maintenance (Visit)	☐	Visit	0	0.00	125.00	**0.00**	
Activity therapy (15 min)	☐	15 minutes	0	0.00	16.00	**0.00**	
Transportation Total:							**1211256.00**
Transportation (Hour)	☐	Hour	431	24.00	17.00	**175848.00**	
Transportation (One-Way-Trip)	☐	One-Way-Trip	1166	24.00	37.00	**1035408.00**	
Transportation- One-Way-Trip (Each)	☐	Each	0	0.00	37.00	**0.00**	

GRAND TOTAL:	**63950640.12**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	63950640.12
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Care Management Total:							***49036596.12***
Care Management - Site (Month)	☐	*Month*	*13373*	*9.72*	*377.00*	***49004556.12***	
Deinstitutuional CM (OTO)	☐	*OTO*	*4*	*1.00*	*3560.00*	***14240.00***	
MSSP Managed Care	☒	*Month*	*0*	*9.72*	*446.35*	***0.00***	
Deinstitutional CM (Month)	☐	*Month*	*5*	*1.00*	*3560.00*	***17800.00***	
Respite Care Total:							***577450.00***
Respite Out of Home (Day)	☐	*Day*	*19*	*8.00*	*175.00*	***26600.00***	
Respite In-Home (Day)	☐	*Day*	*75*	*15.00*	*141.00*	***158625.00***	
Respite In-Home (Hour)	☐	*Hour*	*100*	*25.00*	*40.00*	***100000.00***	
Respite Out of Home (Hour)	☐	*Hour*	*5*	*20.00*	*40.00*	***4000.00***	
Respite Out of Home (Diem)	☐	*Diem*	*19*	*8.00*	*175.00*	***26600.00***	
Respite Out of Home (15 min)	☐	*15 minutes*	*5*	*80.00*	*10.00*	***4000.00***	
Respite In-Home (Diem)	☐	*Diem*	*75*	*15.00*	*141.00*	***158625.00***	
Respite In-Home (15 min)	☐	*15 minutes*	*99*	*100.00*	*10.00*	***99000.00***	
Supplemental Homemaker Services Total:							***797259.00***
Supplemental Homemaker (Hour)	☐	*Hour*	*238*	*36.00*	*40.00*	***342720.00***	

GRAND TOTAL:	***63950640.04***
Total: Services included in capitation:	*0.00*
Total: Services not included in capitation:	*63950640.04*
Total Estimated Unduplicated Participants:	***13373***
Factor D (Divide total by number of participants):	***4782.07***
Services included in capitation:	*0.00*
Services not included in capitation:	*4782.07*
Average Length of Stay on the Waiver:	*295*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplemental Homemaker (Day)	☐	Day	141	2.00	168.00	47376.00	
Supplemental Homemaker (Event)	☐	Event	185	1.00	51.00	9435.00	
Supplemental Homemaker (Diem)	☐	Diem	168	2.00	168.00	56448.00	
Supplemental Homemaker (15 min)	☐	15 minutes	237	144.00	10.00	341280.00	
Supplemental Personal Care Total:							3762938.00
Supplemental Personal Care (Day)	☐	Day	33	2.00	286.00	18876.00	
Supplemental Personal Care (Visit)	☐	Visit	202	1.00	95.00	19190.00	
Supplemental Personal Care (Hour)	☐	Hour	1707	27.00	40.00	1843560.00	
Supplemental Personal Care (Diem)	☐	Diem	66	2.00	286.00	37752.00	
Supplemental Personal Care (15 min)	☐	15 minutes	1707	108.00	10.00	1843560.00	
Adult Day Care Total:							207600.00
Adult Day Care (Hour)	☐	Hour	7	80.00	30.00	16800.00	
Adult Day Care (Day)	☐	Day	28	35.00	90.00	88200.00	
Adult Day Care (15 min)	☐	15 minutes	6	300.00	8.00	14400.00	
Adult Day Care (Diem)	☐	Diem	28	35.00	90.00	88200.00	
Assistive Technology Total:							172023.00
Assistive Technology (Event)	☐	Event	225	3.00	127.00	85725.00	
Safety equipment device or accessory (Each)	☐	Each	210	3.00	127.00	80010.00	
Electronic medication compliance device (Each)	☐	Each	24	1.00	262.00	6288.00	
Communication: Device Total:							2478390.00
Communication-Device (Event)	☐	Event	638	1.00	50.00	31900.00	
Communication-Device (Month)	☐	Month	2683	9.00	50.00	1207350.00	

GRAND TOTAL:	**63950640.04**
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Total: Services not included in capitation:	63950640.04
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ERS device (Purchase)	☐	Device	519	1.00	50.00	25950.00	
ERS service fee (Month)	☐	Month	2587	9.00	50.00	1164150.00	
Monitoring feature/device (Each)	☐	Each	138	2.00	100.00	27600.00	
Alert or alarm device (Each)	☐	Each	134	2.00	80.00	21440.00	
Communication: Translation/Interpretation Total:							62406.00
Communication - Translation (Hour)	☐	Hour	69	9.00	50.00	31050.00	
Communication - Translation (15 min)	☐	15 minutes	67	36.00	13.00	31356.00	
Community Transition Services (Combined) Total:							36400.00
Moving, Housing & Utility Set-up (Service)	☐	Service	52	1.00	700.00	36400.00	
Community Transition Services: Housing & Utility Set-up Total:							14700.00
Housing & Utility Set-up (Event)	☐	Event	21	1.00	700.00	14700.00	
Community Transition Services: Moving Services Total:							21700.00
Moving Services (Event)	☐	Event	31	1.00	700.00	21700.00	
Consultative Clinical Services Total:							303900.00
Consultative Clinical Services (Visit)	☐	Visit	49	3.00	150.00	22050.00	
Consultative Clinical Services (Hour)	☐	Hour	87	15.00	90.00	117450.00	
Consultative Clinical Services (Day)	☐	Day	42	2.00	150.00	12600.00	
Nutritional counseling, dietician (Visit)	☐	Visit	35	3.00	150.00	15750.00	
Social work visit, in the home (15 min)	☐	15 minutes	33	60.00	22.00	43560.00	
Social work visit, in the home (Diem)	☐	Diem	32	2.00	150.00	9600.00	
Medication training and support (15 min)	☐	15 minutes	27	60.00	22.00	35640.00	

GRAND TOTAL:	**63950640.04**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	63950640.04
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Services NOS: Legal/paralegal services (Hour)	☐	Hour	25	9.00	90.00	20250.00	
Telemonitoring of patient in their home (Month)	☐	Month	20	9.00	150.00	27000.00	
Minor Home Repairs and Maintenance Total:							1420000.00
Minor Home Repair / Maintenance (Event)	☐	Event	887	2.00	400.00	709600.00	
Minor Home Repair / Maintenance (Service)	☐	Service	888	2.00	400.00	710400.00	
Money Management Total:							130580.00
Money Management (Visit)	☐	Visit	14	5.00	50.00	3500.00	
Money Management (Hour)	☐	Hour	103	20.00	30.00	61800.00	
Money Management (15 min)	☐	15 minutes	102	80.00	8.00	65280.00	
Non-Medical Home Equipment Total:							2421842.92
Non-medical Home Equipment (Event)	☐	Event	1937	5.00	125.00	1210625.00	
Misc. therapeutic items and supplies (Each)	☐	Each	969	5.00	125.00	605625.00	
Personal care items (Each)	☐	Each	968	5.00	125.00	605000.00	
Exercise equipment (Each)	☐	Each	6	1.00	98.82	592.92	
Nutritional Services Total:							928544.00
Oral Nutritional Supplements (Event)	☐	Event	351	12.00	62.00	261144.00	
Meals - Home Delivered (Meal)	☐	Home Delivered Meal	401	50.00	20.00	401000.00	
Meals - Congregate (Meal)	☐	Congregate Meal	25	12.00	10.00	3000.00	
Oral Nutritional Supplements (Each)	☐	Each	350	12.00	62.00	260400.00	
Meals - Congregate (Diem)	☐	Diem	25	12.00	10.00	3000.00	
Social Support Total:							214225.00
Social Support (Hour)	☐	Hour	100	25.00	28.00	70000.00	

GRAND TOTAL:	**63950640.04**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	63950640.04
Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Social Support (Day)	☐	Day	54	5.00	100.00	27000.00	
Social Support (Month)	☐	Month	9	9.00	125.00	10125.00	
Social Support (15 min)	☐	15 minutes	100	100.00	7.00	70000.00	
Social Support (Diem)	☐	Diem	53	7.00	100.00	37100.00	
Supplemental Protective Supervision Total:							7380.00
Supplemental Protective Supervision (Day)	☐	Day	9	1.00	150.00	1350.00	
Supplemental Protective Supervision (Hour)	☐	Hour	5	13.00	40.00	2600.00	
Supplemental Protective Supervision (Diem)	☐	Diem	9	1.00	150.00	1350.00	
Supplemental Protective Supervision (15 min)	☐	15 minutes	4	52.00	10.00	2080.00	
Therapeutic Counseling Total:							21000.00
Therapeutic Counseling (Hour)	☐	Hour	12	10.00	84.00	10080.00	
Therapeutic Counseling (15 min)	☐	15 minutes	13	40.00	21.00	10920.00	
Therapeutic Services Total:							124450.00
Therapeutic Services (Hour)	☐	Hour	50	12.00	66.00	39600.00	
Therapeutic Services (Day)	☐	Day	15	2.00	125.00	3750.00	
Therapeutic Services (Visit)	☐	Visit	75	2.00	125.00	18750.00	
Physical therapy, in the home (15 min)	☐	15 minutes	25	48.00	17.00	20400.00	
Physical therapy, in the home (Diem)	☐	Diem	16	2.00	125.00	4000.00	
Physical or manipulative therapy (Visit)	☐	Visit	38	2.00	125.00	9500.00	
Routine foot care, preventative maintenance (Visit)	☐	Visit	37	2.00	125.00	9250.00	
Activity therapy (15 min)	☐	15 minutes	25	48.00	16.00	19200.00	

GRAND TOTAL:	**63950640.04**
Total: Services included in capitation:	0.00
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Total Estimated Unduplicated Participants:	**13373**
Factor D (Divide total by number of participants):	**4782.07**
Services included in capitation:	0.00
Services not included in capitation:	4782.07
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Transportation Total:							***1211256.00***
Transportation (Hour)	☐	*Hour*	*431*	*24.00*	*17.00*	***175848.00***	
Transportation (One-Way-Trip)	☐	*One-Way-Trip*	*583*	*24.00*	*37.00*	***517704.00***	
Transportation- One-Way-Trip (Each)	☐	*Each*	*583*	*24.00*	*37.00*	***517704.00***	

GRAND TOTAL:	***63950640.04***
Total: Services included in capitation:	*0.00*
Total: Services not included in capitation:	*63950640.04*
Total Estimated Unduplicated Participants:	***13373***
Factor D (Divide total by number of participants):	***4782.07***
Services included in capitation:	*0.00*
Services not included in capitation:	*4782.07*
Average Length of Stay on the Waiver:	*295*