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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The significant changes to the approved waiver being made in the renewal application:

- Addition of 2000 participant slots
- Addition of enrollment ratio requiring 60% of new enrollments to consist of transitions from qualified institutional stays
- Included language that allows flexibility around bathroom/kitchenette requirements
- Defined requirement for transition from SNF as 60-day stay in facility
- Specified Adult Residential Facilities as qualified waiver providers
- Specified shared bedrooms as an allowable accommodation in an RCFE/ARF, and specified maximum occupancy requirements for shared bedrooms
- Removed reserve capacity for individuals transitioning from the former San Francisco Community Living Support Benefit Waiver
- Updated requirements for the Augmented Plan of Care waiver service
- Revised frequency of DHCS onsite visits from annual to biennial
- Updated Freedom of Choice description
- Updated description of Notice of Action and Fair Hearing processes
- Added language clarifying that ALW requires full-scope Medi-Cal eligibility with no Share of Cost
- Updated annual nursing facility cost used to set individual cost limit and Factor G
- Updated Appendix J
- Updated Performance Measures

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*):

California Assisted Living Waiver

C. Type of Request: renewal

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.0431
Draft ID: CA.010.04.00

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

Regular Waiver

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

03/01/24

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Assisted Living Waiver (ALW) offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.

Assisted Living services from Tier one to five are provided to eligible participants who live in Residential Care Facilities for the Elderly(RCFE), Adult Residential Facilities (ARFs) or Public Subsidized Housing (PSH) sites. Services are delivered by either the RCF staff or licensed Home Health Agency staff based on the participant's choice of residential setting.

Tier Five was added in an amendment just prior to this renewal. Tier Five is a community residential option for participants who have physical and mental disabilities that make being in other facilities, such as skilled nursing facilities, or in Tiers one through four of the ALW, inappropriate. Participants eligible for Tier Five services will require Nursing Facility Level of Care but will also exhibit severe mental/cognitive disabilities as a result of a traumatic brain injury. They will also have demonstrated one or more failed placements in the past.

Residential Habilitation is available to all tiers, requires prior approval from DHCS Nurse Evaluators and provides for additional, appropriate staff to assist in acquiring, retaining and improving the self-help, socialization and adaptive skills as needed by the participant. This may be one-to-one or some other ratio of staff-to-participant depending on need.

Augmented Plan of Care Development and Follow-up is available to tiers 4 and 5, requires prior approval from DHCS Nurse Evaluators and provides for additional, appropriate staff to have an increased level of contact with the participant. Documentation of this increased level of contact is required to be maintained in the participant's case file. The service is comprised of two parts:

• A behavior assessment or systematic assessment of a participant's behavior that includes a description of their functional and dysfunctional behaviors, the circumstances under which identified behaviors are exhibited and the factors that should be taken into account when developing a programmatic response to the behavior(s). This assessment is followed by the development of a written behavior plan; training personnel to implement the behavior plan; monitoring the effectiveness of the behavior plan; and modifying the plan as necessary. The written behavior plan shall identify those participants who need more structured approaches to address challenging behaviors (such as Residential Habilitation Services).

• Those care coordination activities described under "Care Coordination" plus additional assessment and determination of possible mental health and psychiatric service needs of the participant, including the prescription and management of psychiatric medications. The Care Coordination Agencies (CCA) shall work closely with the County Mental Health plans to coordinate mental health services and ongoing medication management. The increased level of contact with the participant and coordination with County Mental Health is expected to require approximately twice the contact and assistance as persons who receive the routine Care Coordination services.

Every waiver participant receives Care Coordination from an independent CCA. A Registered Nurse (RN) with the CCA administers a semiannual (every six months) assessment for level of care determination. The CCA develops the Individualized Service Plan (ISP) to identify the participant's needs and the methodology to meet those needs. The assisted living provider is either the RCFE, ARF or a Home Health Agency (HHA) in the PSH setting. The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs) Instrumental ADLs (IADLs), meals, transportation, medication administration and skilled nursing as needed. The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division. The HHA renders assisted living services in the PSH setting. The HHA is responsible for meeting the needs of the participant analogous to the RCFE/ARF. Meal preparation may be provided individually in each participant's apartment, or in a common dining area depending on the availability of common space at the PSH site. The HHAs are licensed and regulated by the California Department of Public Health, Licensing and Certification Division (L&C).

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ○ **No**
- ◉ **Yes**

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

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

The ALW is currently implemented in the following counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara, Sonoma and San Francisco Counties.

Additional Counties may be added in the future through an Amendment to this waiver.

☐ **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:

DHCS held stakeholder meetings on May 11, 2018 in Sacramento, California and May 22, 2018 in Los Angeles, California. The purpose of these meetings was to inform Assisted Living Waiver (ALW) stakeholders of the upcoming waiver renewal process, present DHCS' short-term and long-term goals for the ALW, and to request initial stakeholder input for DHCS' consideration in building the renewal application for stakeholder review and feedback. DHCS compiled feedback that was provided verbally during the stakeholder meetings, as well as written submissions to DHCS' ALW email inbox.

During the initial feedback process, stakeholders provided input on the following topics: additional waiver slots, enrollment ratio, clarifying program eligibility requirements, waitlist process, and reimbursement rates. DHCS took note of all feedback received and considered the following update for inclusion in the draft renewal application: Modified language around kitchenette and centralized shower requirements to reduce barriers to provider participation.

On September 7, 2018, an open invitation was posted on the ALW Waiver Renewal website (https://www.dhcs.ca.gov/services/ltc/Pages/ALW-Renewal-.aspx) and Public Registrar to allow all waiver participants, advocates, providers of waiver services, and any other interested party, to provide public comment on the renewal of the ALW Waiver. An invitation was also e-mailed to all active providers and stakeholders inviting them to submit any questions or comments directly to DHCS via the main ALW inbox, ALWP.IR@dhcs.ca.gov. The invitations identified that the draft renewal application was available for review on the ALW Waiver Renewal website and that interested parties also had the option to contact DHCS to request a hard copy of the draft renewal application be mailed to them. The designated DHCS mailing address, phone, and email address contact information to request a hard copy of the draft renewal was provided. The public comment period was open from September 7, 2018 to October 7, 2018.

Tribal notice was not necessary for the renewal application, as per an email correspondence sent to Andrea Zubiate, Coordinator, DHCS Indian Health Program, on August 31, 2018, from Cynthia W. Lemesh, CMS Native American Contact, stating: "We (CMS) concur with the request for no tribal notice for the renewal."

DHCS received a total of 26 comments from 8 entities on the renewal application during the public comment period. All comments came from Care Coordination Agencies or provider/advocate groups. Major themes of the feedback and DHCS responses are summarized below:

- Clarifying eligibility requirements

o Comment: We view the no share of cost requirement as simply clarifying that beneficiaries with a Medically Needy eligibility determination must also have a zero share of cost in order to be able to participate in the ALW. Otherwise, beneficiaries with a Medically Needy eligibility determination who do have a share of cost would not be able to participate in the ALW. We appreciate DHCS' clarification.

o DHCS Response: DHCS concurs with the comment. To clarify, beneficiaries with a Medically Needy eligibility determination must also have a zero Share of Cost (SOC) in order to complete enrollment into the ALW. Beneficiaries with a Medically Needy eligibility determination who do have a SOC would not be able to enroll in the ALW. The County determines a beneficiary's SOC. Upon approval of an application for the ALW program, the CCA and/or member should contact the County to request a redetermination to an aid code that is absent SOC.

- Feedback on the enrollment/waitlist process

o Comment: The Department should notify applicants directly about their placement on the wait list, estimate of when an open slot will become available, and allow retroactive enrollments up to 3 months prior to the month of application for any time period during which the member met eligibility requirements.

o DHCS Response: DHCS notifies the Care Coordination Agencies (CCA) monthly as to where we are on the ALW Waitlist. It is our expectation, as outlined in the ALW Waitlist Policy and Procedures, that CCA's are tracking who they have on the waitlist along with the date that beneficiary was added to the waitlist. It would duplicate efforts for DHCS to provide updates to applicants. DHCS monitors CCAs to ensure they are contacting waitlist applicants to inform them of the status of the waitlist. In regard to retro enrollment, when a beneficiary is added to the ALW waitlist, a complete application has not been submitted, a nurse assessment has not been conducted and in some cases, the individual does not have Medi-Cal. Because of this we cannot retro date an enrollment to a beneficiary who may not have qualified for the ALW program at the time they were added to the waitlist.

DHCS did not make substantive changes to the renewal application in response to public comments.DHCS made the following minor revisions to the application in response to items raised by stakeholders:

- In the Major Changes section, clarified that the 60-day requirement for institutional transition is a new requirement,

not a revision.
- Included flexibility around bathroom/kitchenette requirements
- Updated the frequency of visits by the Department of Social Services to RCFE/ARF from every 5 years to annually.
- Updated reference to the California Community Transitions Program on pg. 112, specifically: "The ALW is working closely with the CCT program and it is anticipated that all additional NF transitions will be in conjunction with CCT while that program or successor program remains active."
- Updated NF Transition rate to reflect rate increases in Appendix I and Appendix J.

DHCS holds regular meetings to engage Care Coordination Agencies and provide technical assistance on program issues. DHCS strives to respond to public and provider input in a proactive manner as circumstances allow.

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

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

7. Contact Person(s)

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

Last Name: Joseph

First Name: Billingsley

Title: Chief,

Agency: DHCS

Address: 1501 Capitol Ave.

Address 2: PO Box 997437

City: Sacramento

State: **California**

Zip: 95899

Phone: (916) 713-8389 **Ext:** ☐ **TTY**

Fax:

(916) 440-5720

E-mail: Joseph.Billingsley@dhcs.ca.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **California**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **California**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Integrated Systems of Care Division

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Appendix A: Waiver Administration and Operation

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

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

◉ **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:

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

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

Appendix A: Waiver Administration and Operation

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

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:

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
Participant waiver enrollment	☒
Waiver enrollment managed against approved limits	☒
Waiver expenditures managed against approved levels	☒
Level of care evaluation	☒
Review of Participant service plans	☒
Prior authorization of waiver services	☒
Utilization management	☒
Qualified provider enrollment	☒
Execution of Medicaid provider agreements	☒
Establishment of a statewide rate methodology	☒
Rules, policies, procedures and information development governing the waiver program	☒
Quality assurance and quality improvement activities	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Administrative Authority and Oversight: The number and percent of complete provider applications received from CCAs that received approval by DHCS Numerator: Number of applications received from CCAs that obtained DHCS approval and resulted in ALW program enrollment during the waiver year. Denominator: Total number of CCA applicants with complete applications received that waiver year.

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

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 Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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**

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

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

DHCS conducts continuous and on-going review of the assessments as submitted by the CCAs. DHCS conducts biennial quality assurance on-site, desk, and/or virtual visits to the CCAs to verify that the assessments as completed by the CCAs match the needs of the participant and are fully implemented.
On-Site, desk, and/or virtual visits are also conducted on RCFE/ARF providers on a continuous basis.

DHCS conducts the following oversight functions pertaining to CCAs:
- Provide a folder for each CCA with documentation of waiver requirements for each resident chart.
- Review current personnel files for each employee.
- Review CCA Satisfaction Survey Flyer and ask for annual survey results. (QA)
- Review CCA flyer how/who to report abuse, neglect, exploitation. (QA)
- Review CCA Staff Annual Training/In Service/Education.
- Ensure CCA has translated written materials into English, Spanish, and/or threshold language. (QA)
- Review Serious Incident Reporting with CCA.
- Review ISP, IN, FOC, Amenity Form, 602 with medication list, 603 with CCA.
- Review Emergency /Evacuation Plans with CCA.
- Onsite visits are conducted annually, with the compliance team visiting numerous sites per region. During these onsite reviews, DHCS staff will review facility training with staff, operational and logistic functions, as well as additional waiver requirements. Ad hoc visits will typically be triggered based on Serious Incident Reporting, and that will take a precedent over routine annual visits. Complaints from beneficiaries, as well as CAPs on facilities, can also trigger ad hoc reporting, and technical assistance will be provided via onsite visits, and/or conference calls depending on the nature of the situation in question.

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.

Remediation:

Any non-compliance will result in the DHCS contacting the CCA to:
*review the LOC data
*determine etiology of non-compliance
*develop Corrective Action Plan (CAP) and timeline as appropriate.

Resolution Follow-up:
DHCS will:
*follow up in writing to determine if the CAP was completed with a successful outcome
*monitor the change(s) for continuing compliance

DHCS will conduct a biennial QA audit and generate a report summarizing the data and the findings regarding the LOC determinations. DHCS is responsible for the identification and prioritization of the problems as presented. The CCAs are responsible for the remediation of the problems and the efficacy of this process is to document in the subsequent assessment submission period. DHCS will provide further Technical Assistance (TA) to the CCAs as required to assure that the remediation occurs and is continuous.

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: DHCS will conduct a biennial QA audit. DHCS will provide further TA to the CCAs to assure remediation occurs and is continuous.

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)**	21	64	
	☒	**Disabled (Other)**	21	64	

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ 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:

Eligible participants for Tiers one through five are determined to be at the Nursing Facility Level A or Nursing Facility Level B Level of Care as per the California Code of Regulations (CCR) Sections 51120 (Intermediate Care Services, NF-A) and 51124 (Skilled Nursing Services NF-B).

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:

There is no maximum age limit for this waiver.

DHCS is unable to submit the application selecting "Not Applicable". Appendix B-1-a requires Maximum Age Limit to be entered for the disabled subgroup.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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:

The costs for the ALW services are designed not to exceed the annual sum of the Nursing Facility (NF) rate of $76,157.00 plus the estimated state plan costs for persons in the NF setting of $8,000.00. The rates for the five tiers of service, plus the cost of care coordination with the other waiver services, combined, are set to maintain cost neutrality.

CCA RNs utilize an assessment tool based on the Minimum Data Set (MDS) to score the participant's acuity (tier level) and to identify the services that are required to meet his or her need(s) in an RCFE/ARF. Should the participant be determined at any of the tiered levels, and can be maintained safely in the community with the services provided through the waiver, the participant is eligible to enroll.

Participants are notified of their right to request a Fair Hearing if enrollment is denied due to the cost limit.

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

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

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

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

Only the DHCS RN may authorize additional services for individuals with traumatic brain injury or those participants who meet all of the following specific criteria:

• Meets NF-A or NF-B Level of Care with severe mental/cognitive disabilities usually as consequence of a traumatic brain injury ;

• Demonstrates, has a history of or has the potential of wandering or flight behavior;

• Demonstrates or has a history of an inconsistent ability to provide self-care, potential of injury to self or others, or potential of behavior outbursts that negatively affect others;

• Demonstrates or has a history of unsuccessful attempt(s) of placement in other community settings;

• Requires potential 24-hours/seven days per week hands-on or physical presence supervision and management; can be left alone for short periods of time; and,

• Only able to reside in a community setting licensed to provide 24-hour services, supervision and supports, demonstrated by at least one failed placement in a less restrictive setting.

CCA must document the need for additional services in an Individual Service Plan. Additional services will be authorized at the time DHCS RN reviews and approves each participant's ISP, and DHCS' approval will be documented in the ISP.

Note: Diagnostic criteria will not be used as a determinant of need. Each individual will be assessed according to their needs, not their diagnosis.

☒ **Other safeguard(s)**

Specify:

Should a participant develop needs with associated costs that exceed the individual cost limit, the DHCS in conjunction with the CCA would work cooperatively with the participant to achieve cost neutrality. The DHCS will assist to determine if there are choices that the participant may exercise to alleviate the excessive costs. The expected goal is to enable the participant to remain enrolled in the waiver.

In the event that the participant is not able to remain within cost neutrality, is being non-compliant with their ISP, refuses to pay rent, or jeopardizes the health and well-being of other participants, the DHCS, in conjunction with the CCA, would assist to determine alternative placement that would enable the participant to receive the needed care in the least restrictive environment. The decision to relocate would be in conjunction with the participant's wishes, consistent with the prescribing physician's orders, and will preserve the health, safety and well-being of the participant in the least restrictive setting. Primary consideration would be given to another waiver program or to independent living with IHSS and/or other supportive care. If all avenues of community placement have been exhausted the participant has the choice of nursing facility placement or remaining in community housing without waiver services.

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	

Waiver Year	Unduplicated Number of Participants
	7409
Year 2	7409
Year 3	9660
Year 4	13050
Year 5	16440

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	5744
Year 2	5744
Year 3	7488
Year 4	10116
Year 5	12744

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in**

the waiver.

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Each waiver participant is determined to be at the NF LOC by the electronically scored Assessment Tool as administered by the CCA. The participant is determined to be at one of the five tiers by the Assessment Tool. Tier One approximating the NF-A LOC, and Tiers Two through Five being gradations of the NF-B LOC.

Enrollment may be prioritized based upon the imminent need for services that is determined through the assessment process. New enrollments into the ALW are required to be processed at a ratio of 60% institutional transition to 40% community enrollments. Participant must reside in an institution for at least 60 days prior to qualifying as an institutional transition onto the Waiver. An individual requesting ALW services must work with a Care Coordination Agency to complete and submit an ALW application to DHCS. If the application is not complete or additional information is needed, the application will be deferred. If there are no waiver slots available, applicants who potentially meet the waiver's LOC criteria will be placed on the waitlist. DHCS will then contact the Care Coordination Agency confirming the receipt of the application request which will include the effective date of placement on the ALW waitlist. When a waiver slot becomes available, the Care Coordination Agency will be notified and given 60 days to submit a completed application to DHCS for review and approval. If a completed application is not received by DHCS within 60 days, the open slot will rotate to the next person on the waitlist and the requestor will be placed at the bottom of the list at their request or removed from the waitlist.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

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

- (●) **No**

○ **Yes**

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

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

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

☒ **SSI recipients**

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

☒ **Optional state supplement recipients**

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

Select one:

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

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

All other mandatory and optional groups under the plan.

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:

Total Income, including any income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility determination.

○ **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:

  Total Income, including any income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility determination.
- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate 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 (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-5-a 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 that you do not need to complete this section and therefore this section is not visible.

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: 2

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

The CCA must employ a Registered Nurse (RN) to administer the Assessment Tool as developed for the ALW and shall be authorized to provide Care Coordination or the additional Service Assessment/Plan of Care Development services only when he/she meets the requirements specified below.
A. Have and maintain a current, unsuspended, un-revoked license to practice as a R.N. in the State of California.
B. Have work experience that includes at least one of the following:
1) A minimum of 1000 hours of experience in an acute care setting providing nursing care to patients with similar care need(s).
2) A minimum of 2000 hours of experience in a home setting(s) providing nursing care to patients with the similar care need(s).

Complete training on use of the ALW Assessment Tool, the ALW ISP, and training on the Care Coordination Procedures Manual as provided by the DHCS.

CCAs are responsible for submitting completed ALW Assessment Tool to Registered Nurses employed by DHCS for review and final determination of LOC.

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

(if applicable), including the instrument/tool utilized.

The LOC criteria are based on the CCR Sections 51120 (Intermediate Care Services, NF-A) and 51124 (Skilled Nursing Services NF-B). Persons eligible for the ALW are determined to meet the LOC by the electronically scored Assessment Tool.

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.

The Assessment Tool is based on the Minimum Data Set (MDS) and is designed to facilitate the assessment and determination of waiver eligibility by the CCA RN. The Assessment Tool is electronically scored in an Excel spreadsheet format. The CCA RN enters the data and the Assessment Tool automatically specifies the tier(s) of service for an eligible participant. The Assessment Tool was alpha and beta tested prior to implementation and was updated to strengthen the validity of the tool. The Assessment Tool provides a consistent determination of waiver eligibility and has demonstrated consistency from user to user.

The Assessment Tool used by ALW is different from the tools used to determine institutional LOC because it is designed to determine not only LOC but also a specific tier level exclusive to ALW services and the daily rate that will be paid to the RCFE or HHA to provide the necessary daily care. These tier levels are based on the waiver participants care needs. As care needs change the participant's tier level will change.

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:

Level of care evaluation/reevaluation process: CCAs conduct assessments and compile the information necessary to submit LOC evaluations to the state for final determination. CCAs complete an Assessment Tool that automatically tallies a score that identifies the participant's tier level. Waiver participants are reassessed every six months. The same Assessment Tool is used for the reassessment. The DHCS reviews 100% of all assessments and reassessments to make the final determination.

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):*

The CCA RN performs the reassessments. They are allowed 30 days before or after the due date to complete the reassessment, and an additional seven days to complete the ISP (commonly referred to as a plan of care) and submit all documents to the DHCS. DHCS sends reminders to submit reassessments timely. During the audit process, DHCS reviews whether CCAs have been meeting the required reassessment schedule. CCAs will be required to submit a Corrective Action Plan if DHCS finds that they are not conducting reassessments timely.

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:

All original records are maintained by the CCA for a minimum of ten years. Copies are retained by the DHCS and the RCFE/ARF providers.

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:
Initial level of care: the number/percent of new enrollees that received an initial LOC determination by CCA RN. Numerator: Number of new enrollees, in the current waiver year, that had case files reviewed with an initial LOC completed by RN. Denominator: number of new enrollee case files reviewed during the waiver year.

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

Record reviews, MedCompass

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: Every six months	

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 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:
The assessment processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care. Numerator: Number of case files reviewed of participants with assessment processes and instruments applied appropriately. Denominator: Total number of participant case files reviewed during the waiver year.

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

Data Aggregation and Analysis:

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

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

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

Discovery:
Initial - DHCS reviews 100% of the assessments as submitted to ensure that the LOC determination was made. DHCS will conduct biennial Quality Assurance audits. DCHS will visit a random sample of enrolled participants and review the charts in both the CCA offices and in the RCFE/ARF/PSH settings. In the event that an irregularity or inconsistency is detected with the Assessment Tool, it will be modified and corrected and the Assessment Tool Handbook will be updated to reflect the changes and improvements to the Assessment Tool, and the CCAs will be provided with training and TA to adopt and implement the revised Tool.

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.

Remediation: Within 60 calendar days of discovery, any non-compliance will result in the DHCS contacting the provider to:
1. review the data
2. determine etiology of non-compliance; and
3. develop the Corrective Action Plan (CAP) with timeline

Resolution Follow-up: The DHCS will:
1. follow up to determine if the CAP was completed with successful outcome; and
2. monitor the change(s) for continuing compliance.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

Exclusivity contracts are prohibited. The CCAs will provide participants choices of available providers based on their needs/preferences and not on biases towards providers. The participant signs the Freedom of Choice document indicating their choice of the ALW as the preferred option for the delivery of services. The participant has the right to decline the waiver services at any time.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The original is maintained by the CCA and the DHCS is provided with a copy at the time of initial authorization of services.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting

Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

DHCS employs several methods to ensure meaningful access to waiver services by Limited English Proficient (LEP) individuals, in accordance with §50514 of the Health and Safety Code and §10746 of the Welfare and Institution (W&I) Code.

Participating waiver providers are required to provide both interpreter and translation services for applicants and participants in the Medi-Cal threshold languages most commonly encountered in that county. Threshold languages differ by county and are identified by DHCS at the following link: https://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Enrollment_by_Geographic_Region.aspx. A “threshold” is defined as 3,000 beneficiaries or 5% of the Medi-Cal population within a county (whichever is lower) whose primary language is other than English.

Language services shall be provided in compliance with the Code of Federal Regulations, Title 45, section 92.201, and any other applicable federal or state laws or regulations.

DHCS will furnish participating counties and waiver providers with translated written materials in English and Spanish, as well as threshold languages most commonly encountered in the county.

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	**Assisted Living Services - Homemaker; Home Health Aide; Personal Care**		
Statutory Service	**Care Coordination**		
Statutory Service	**Residential Habilitation**		
Other Service	**Augmented Plan of Care Development and Follow-up**		
Other Service	**NF Transition Care Coordination**		

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):

Assisted Living Services - Homemaker; Home Health Aide; Personal Care

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The following is a list of services provided or coordinated by either the RCFE/ARF waiver provider or HHA waiver provider for participants residing in Public Subsidized Housing (PSH):

- 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs (Provision of awake staff at night is waived in 6-bed RCFE/ARFs as per CCL);

- Provision and oversight of personal and supportive services including assistance with ADLs and IADLs;

- Assistance with self-administration of medications and/or administration by licensed nursing staff as needed;

- Recreational activities (Referral to recreational activities in a PSH setting);

- Provision of three meals per day plus snacks in the RCFE/ARF setting; or,

- Coordination of three meals and snacks in a PSH setting;

- Housekeeping and laundry (Participant provides cleaning products and coins for laundry equipment);

- Licensed nursing staff, as necessary, to meet the skilled nursing needs of the participants. This does not include 24-hour skilled nursing care or continuous skilled nursing supervision.

- Transportation, or arrangement of transportation, to medically necessary appointments and to other needed services as identified on the ISP. The use of public transportation, when safe and appropriate, is an option.

- An IRS is required in the PSH setting. An IRS is a 24-hour call system that enables participants to secure immediate assistance in the event of an emotional, physical or environmental emergency. The IRS is designed to meet the needs and abilities of participants. The IRS may be a 24-hour response system, paging or intercom system.

Accommodations that must be available in ALW settings include:

- Private or shared bedroom with lockable door in an RCFE/ARF. A shared bedroom shall have no more than two residents, maximum;

- Private occupancy in PSH with doors that lock, unless sharing is the participant's preference. (The choice of a housemate or roommate is independent of the ALW

- Private or semi-private bathroom in an RCFE/ARF or private full bathroom in PSH; There must be adequate bathroom space for the privacy and dignity of the participants when bathrooms are semi-private. This requirement shall not prevent an RCFE from developing or using a centralized shower designed to better accommodate residents with disabilities or to better allow for staff assistance with a resident’s shower;

- Shared common space, such as a dining room or common activities center that may also serve as a dining room;

- Kitchenette, equipped with a refrigerator, a microwave (or cooking appliance in PSH) and storage space for utensils and supplies if participants do not have access to a common kitchen area at all times. The kitchenette requirement is waived if use of the kitchenettes is not allowed under the relevant licensure regulations for Residential Care Facilities for the Elderly.

- PSH sites must have space sufficient for an HHA to operate a workspace with lockable doors and a telephone line;

- PSH sites must allow building access to identified employees for the purpose of rendering the ALW benefit.

- Note: These services do NOT include the cost of rent or the purchase of food.

Assisted Living Services will be delivered to participants in one of five possible "tiers" of service. Participants will be assigned an ALW tier as determined by the Care Coordination Agency RN. ALW Assessment Tool is administered by the CCA RN to potential, new participants to the waiver, and repeated at each reassessment. The tool measures the need for assistance with ADLs, IADLs and the need for assistance in one or more of the seven (7) functional categories: Cognitive Patterns, Behavioral Symptoms, Continence, Communications, Medications, Skin Conditions, or Other Treatments. Based on the combined need for assistance in these areas, the tool calculates a LOC eligibility and tier of service for the participant.

• Tier one services will be assigned to participants with the lowest level of support need;

• Tier two, tier three, and tier four services will be assigned to participants with more significant support needs, respectively;
and;

• Tier five services will be assigned to participants who require intense, focused attention to ADLs and IADLs as a result of a severe traumatic brain injury. These participants will have a need for assistance beyond that provided in Tiers one through four along with the additional residential habilitation services to successfully manage their care needs while residing in either an RCFE/ARF or PSH. Tier five is designed to provide a community residential alternative for participants whose physical, mental and cognitive disabilities make placement in other facilities, such as SNFs, IMDs, ICF/DDs or in Tiers one through four of the ALW inappropriate or unmanageable. To be eligible for Tier five, participants must demonstrate one or more failed placements in the past, and demonstrate that they can successfully reside in a supervised community setting. Tier five provides extensive physical, behavioral, cognitive, communicative, social and psychosocial treatments and supervision for those ALW-eligible participants with care needs typical of severe traumatic brain injury.

To be eligible for Tier five services a participant must have suffered a traumatic brain injury and meet all of the following specific criteria:

• Meets NF-A or NF-B LOC with severe mental/cognitive disabilities;

• Demonstrates, has a history of or has the potential of wandering or flight behavior;

• Demonstrates or has a history of an inconsistent ability to provide self-care, potential or injury to self or others, or potential of behavior outbursts that negatively affect others;

• Demonstrates or has a history of unsuccessful attempts(s) of placement in other community settings;

• Requires potential 24-hours/seven days per week hands-on or physical presence supervision and management; can be left alone for short periods of time; and,

• Only able to reside in a community setting licensed to provide 24-hour services, supervision and supports, demonstrated by at least one failed placement in a less restrictive setting.

Assisted Living Services, as all ALW benefits, will be delivered in accordance with an ISP. The ISP is based on the needs identified by the CCA RN via the ALW Assessment Tool, clinical records, professional assessments and the personal preferences of the participant.

The participant takes part in the development of the ISP to the full extent possible. The CCA will meet with the participant, direct caregivers, and facility administrator during development of the ISP to ensure the participant's needs, goals, preferences, and care requirements are all properly addressed. Family members can participate upon request or approval by the waiver participant. If the participant is unable to participate in the development of their own ISP, the person(s) responsible for a participant's health care decisions may fill the lead role in plan development and oversight in collaboration with the provider and the CCA as necessary.

Assisted Living Services includes personal care services (including assistance with ADLs and IADLs as needed), chore services, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. This service includes 24-hour on-site direct care staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

Assisted Living Services include personalized care, available 24-hours per day rendered by onsite staff. Direct care staff will be awake and available at all times. An exception to the requirement of awake staff at night is granted to RCFE/ARFs with a licensed capacity of fewer than seven beds. In RCFE/ARFs with a licensed capacity of fewer than seven beds, direct care staff must be available on the immediate premises but are not required to remain awake throughout the night. Assisted Living Services are furnished to participants who reside in private or semi-private residency units which may be shared at the participant's request but not as a requirement of program participation. The ISP will reflect the choice of the participant to share a residence. The participant has a right to privacy. Residences may be locked at the discretion of the participant, except when a physician or mental health professional has certified in writing that the participant is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code). Each residence is separate and distinct from the other.

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	Residential Care Facility for the Elderly (RCFE)
Agency	Home Health Agencies (HHAs) in Publicly Subsidized Housing (PSH) Settings
Agency	Adult Residential Facility (ARF)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Assisted Living Services - Homemaker; Home Health Aide; Personal Care

Provider Category:

Agency

Provider Type:

Residential Care Facility for the Elderly (RCFE)

Provider Qualifications

License *(specify):*

RCFs must meet licensure and certification requirements set forth by the CCL. Participating RCFs must be in substantial compliance and good standing with licensing regulations (Ref: Title 22, § 87101(s)(9)). RCFs that are on probation with and/or have pending accusation against the licensee are not in substantial compliance for the purpose of the ALW. (Ref. H&S § 1569.33).

Certificate *(specify):*

Other Standard *(specify):*

DHCS maintains an active list of RCF applicants and providers that DHCS makes available to CCL for review and monitoring of facility status. CCL notifies the DHCS of any change in provider status for waiver providers.

Individual RNs and social workers are not provider types approved to provide services under the ALW. However, a qualified RN or social worker may be contracted or hired by the RCF to provide necessary services to participants based on the participant's individual service plan. Individual RNs and social workers may operate as a business to provide ALW services as a CCA provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDSS CCL

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Assisted Living Services - Homemaker; Home Health Aide; Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agencies (HHAs) in Publicly Subsidized Housing (PSH) Settings

Provider Qualifications

License *(specify):*

HHA Title 22, §§74659 et seq.

Certificate *(specify):*

CHHA BPC §§1736.1-1736.6

Other Standard *(specify):*

In PSH residences, Assisted Living Services are provided by Medi-Cal licensed Home Health Agencies (HHAs). \

All HHAs must:
1. Possess a State of California business license, be licensed as a Home Health Agency in California, and be certified as a Medi-Cal provider of home health services.
2. Be in substantial compliance with all licensing regulations and in good standing with the licensing agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Assisted Living Services - Homemaker; Home Health Aide; Personal Care

Provider Category:

Agency

Provider Type:

Adult Residential Facility (ARF)

Provider Qualifications

License *(specify):*

ARFs must meet licensure and certification requirements set forth by the CCL. Participating ARFs must be in substantial compliance and good standing with licensing regulations (Ref: Title 22 – Division 6 – Chapter 6 – Adult Residential Facilities). ARFs that are on probation with and/or have pending accusation against the licensee are not in substantial compliance for the purpose of the ALW. (Ref. H&S § 1569.33). Prior to the CAP being lifted, the facility and their affiliates, must be in substantial compliance with licensing and regulations, and in good standing with the corresponding licensing agency, with full power and authority to carry on its business as such business is now conducted and as proposed to be conducted. DHCS reserves the right as the single-state Medicaid Agency to utilize findings from the CCL as a means to incorporate deficiencies of the ARFs.

Certificate *(specify):*

Other Standard *(specify):*

DHCS maintains an active list of RCFE/ARF applicants and providers that DHCS makes available to CCL for review and monitoring of facility status. CCL notifies the DHCS of any change in provider status for waiver providers.

Individual RNs and social workers are not provider types approved to provide services under the ALW. However a qualified RN or social worker may be contracted or hired by the RCFE/ARF to provide necessary services to participants based on the participant's individual service plan. Individual RNs and social workers may operate as a business to provide ALW services as a CCA provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDSS CCL

Frequency of Verification:

Annual

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 Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Care Coordinators assist participants in gaining access to needed waiver and other state plan services. In collaboration with participants and/or their families, the Care Coordinators will complete the assessment and reassessment of waiver participants using the ALW Assessment Tool, at least every six months, and more frequently, as indicated by a change in the condition of the participant. A CCA RN must conduct the assessment and complete the Assessment Tool. Care Coordinators must also verify Medi-Cal eligibility. Care Coordinators will assist participants in the direct development, implementation, and modification of their ISP to the extent that the participant desires to be involved. Participants who are unable to direct the development of their own ISP and participate in the oversight of their own services may be assisted by a family member or other responsible party, such as a legal conservator. The person(s) responsible for a participant's health care decisions may fill the lead role in plan development and oversight in collaboration with the Care Coordinator as necessary.

The ISP is a plan describing the services rendered to the participant, the manner in which the services are delivered, and the desired outcome for each service. The ISP must include specification of the type of provider performing each service and the frequency and duration of each service. Participants may choose to be involved in all aspects of the design, delivery, and modification of their services. They have the right to decide when services are delivered, where services are delivered and how services are delivered.

The Care Coordinator will ensure that the ISP is completed during the initial meeting and reviewed (and updated as needed) every six months. On an ongoing basis, Care Coordinators, in collaboration with participants, will also be responsible for ensuring the appropriate, timely delivery of needed services. This will be achieved through face-to-face meetings with the participant and/or responsible parties every month, and a review of participant records at each six-month reassessment. Participants may request a review of their ISP at any time. The Care Coordinator assessments and determinations of Medi-Cal eligibility are subject to verification by the DHCS. Every six months a Care Coordinator RN will reassess participants and determine with the participant what, if any, updates need to be made to the ISP. The Care Coordinator will assess the participants for health and safety. Any signs of abuse or neglect will be reported immediately to Adult Protective Services (APS), and the DHCS. Depending on whether the participant is residing in an RCFE/ARF or PSH, CCL or DPH L&C will also be notified.

Participants will be enrolled into the ALW upon completion of the Assessment, verification of eligibility and completion of the Freedom of Choice Document. The Care Coordinator is eligible to submit bills for Care Coordination once the participant is enrolled. A participant can only be enrolled into the waiver after having been transitioned into an assisted living community residence.

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

Care Coordination is on-going for the duration of time the participant is enrolled in the waiver. If a participant leaves the assisted living setting due to hospitalization, etc…the CCA will continue to advocate for the participant for up to thirty days for the purpose of coordinating the participant returning to the assisted living setting. If the participant is unable to return after 30 days, the participant will be disenrolled from the ALW. The participant retains the unduplicated slot for 60 days to facilitate subsequent return to the ALW. After 60 days, the slot is available to another participant.

The emphasis of the ALW is the successful transition of persons from skilled nursing into assisted living based on freedom of choice. The goal is for the CCAs to coordinate at least one NF transition for every one community placement they coordinate.

The CCAs will work in conjunction with the Money Follows the Person (MFP) program, known in California as California Community Transitions (CCT) to assist with the successful placement of persons identified by CCT who choose the ALW. The CCAs will consider the placement of a CCT individual as a qualifying NF transition. The CCT Operational Protocol recognizes the PSH sites as an appropriate placement. Should a participant in the CCT demonstration choose to reside in an RCFE/ARF, the CCT demonstration would refer the participant to a CCA for enrollment in the ALW.

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 Coordinator Agency (CCA)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:

Agency

Provider Type:

Care Coordinator Agency (CCA)

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Other Standard *(specify):*

Care Coordination Agency
Minimum Requirements for Care Coordination Agency (CCA)
Agency Experience and Staff Requirements

A Care Coordination Agency must employ the following staff with the required years of experience providing care coordination, which includes the following activities: conducting assessments, developing care plans, arranging for and monitoring service delivery, maintaining progress notes and case records, conducting quality assurance reviews, and collecting data.

Registered Nurse (RN):
A RN must have and maintain a current, unsuspended, un-revoked license to practice as an RN in California and have work experience that includes either a minimum of 1,000 hours in an acute care hospital or a minimum of 2,000 hours of experience in a home health setting.

Individual RNs and social workers are not provider types approved to provide services the ALW. However, a qualified RN or social worker may be contracted or hired by the RCFE/ARF to provide necessary services to participants based on the participant's individual service plan. Individual RNs and social workers may operate as a business to provide ALW services as a CCA provider.

A Social Worker must have either a bachelor or master degree in social work, psychology, counseling, rehabilitation, gerontology, or sociology plus one year of related work experience.

Agencies must have mandatory annual in-service training programs for their staff. In-service training must include training on the HCB setting requirements at 42 CFR 441.301(c)(4)-(5), person-centered planning, and how to properly complete the ISP.
Agencies must have a process for soliciting and/or obtaining feedback from clients regarding their satisfaction with service.
Agencies must have a quality assurance program to track client complaints and incident reports.
Agencies must maintain a service record for each client. At a minimum, the record must contain all required forms, completed assessments, signed care plans (ISPs), and progress notes. Agencies must agree to make these records available to DHCS for audit.

Agencies must have contingency plans to deliver services in the event of a disaster or emergency.
Staff must agree to collect data as specified.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS upon application as an ALW provider and during annual review

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

As defined in §1915(c)(4)(B) of the SSA, habilitation services are "…designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings."

The residential habilitation service includes assistance with ADLs, but with the focus of overseeing the behavioral issues requiring a constant and concentrated effort for up to 16 hours per day, 7 days a week involving the addition of the specialized behavior modification techniques related to such issues as TBI. Provision of this service requires prior approval from DHCS every six months to allow additional, appropriate staff to focus individual attention on one participant to assist in acquiring, retaining and improving the self-help, socialization and adaptive skills while concentrating on helping them to control their behavior issues that would otherwise preclude them from living in a community setting. Providers will be reimbursed for supplying additional, appropriate staff to oversee a participant, depending on an individual's unique needs. Staff may be licensed medical staff, personal or nursing aides, security personnel, or other specialties as appropriate to the specific participant. Staff must have had a minimum of two hours of documented approved education, specific to TBI and a minimum of two hours of documented approved continuing education per year thereafter. Providers must document treatment goals, timeframes, and ongoing daily status. This document must be provided to DHCS for review prior to authorization by DHCS.

Specific services are an intensive form of those specified under the Assisted Living Services and specifically aimed at those participants who require more staff and more intense focus on the activity and the participant's safety and well-being than that anticipated for the participant receiving routine assisted living services. Services may include:

- Hands-on assistance with ADLs such that the participant is guided to become more self-reliant; such enhanced assistance is anticipated to take up to twice as long as that provided to those participants receiving routine assisted living services.

- In-person, eyes-on supervision/protective supervision to redirect the participant away from wandering, acting out behaviors, violent behaviors, self-destructive or other person-destructive behaviors.

- Such oversight is expected to require staff that is assigned a limited number of participants for an extended time.

Residential habilitation services are available to participants residing in both an RCFE/ARF and a PSH. Residential Habilitation Services will be provided by the home health agency in addition to regular Assisted Living Services to participants residing in PSH settings.

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

Reimbursed per 15 minute increments, based on prior authorization as outlined on the ISP for the amount of time needed for the specific participant. Providers may bill a maximum of 24 hours per day (96 units).

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	PSH - HHA
Agency	RCFE
Agency	ARF

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

PSH - HHA

Provider Qualifications

License *(specify):*

CA Dept. of Public Health (CDPH) issued HHA license.

Certificate *(specify):*

Medi-Cal certified provider.

Other Standard *(specify):*

In PSH residences, Assisted Living Services are provided by Medi-Cal licensed Home Health Agencies (HHAs).

A PSH-HHA must:
1. Possess a State of California business license, be licensed as a Home Health Agency in California, and be certified as a Medi-Cal provider of home health and ALW services.

2. Be in substantial compliance with all licensing regulations and in good standing with the licensing agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH L&C

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

RCFE

Provider Qualifications

License *(specify):*

CDSS CCL issued RCFE license.

Certificate *(specify):*

Other Standard *(specify):*

RCFEs must meet licensure and certification requirements set forth by the CCL. Participating RCFEs must be in substantial compliance and good standing with licensing regulations (Ref: Title 22, § 87101(s)(9)). RCFEs that are on probation with and/or have pending accusation against the licensee are not in substantial compliance for the purpose of the ALW. (Ref. H&S § 1569.33). The DHCS maintains an active list of RCFE applicants and providers that is provided to CCL for review and consideration of facility status. CCL notifies the DHCS of any change in provider status for waiver providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDSS CCL

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

ARF

Provider Qualifications

License *(specify):*

ARFs must meet licensure and certification requirements set forth by the CCL. Participating ARFs must be in substantial compliance and good standing with licensing regulations (Ref: Title 22,Division 6,Chapter 6-Adult Residential Facilities). ARFs that are on probation with and/or have pending accusation against the licensee are not in substantial compliance for the purpose of the ALW. (Ref. H&S § 1569.33). Prior to the CAP being lifted, the facility and their affiliates, must be in substantial compliance with licensing and regulations, and in good standing with the corresponding licensing agency, with full power and authority to carry on its business as such business is now conducted and as proposed to be conducted. DHCS reserves the right as the single-state Medicaid Agency to utilize findings from the CCL as a means to incorporate deficiencies of the ARFs.

Certificate *(specify):*

Other Standard *(specify):*

DHCS maintains an active list of ARF applicants and providers that is provided to CCL for review and consideration of facility status. CCL notifies the DHCS of any change in provider status for waiver providers.

Individual RNs and social workers are not provider types approved to provide services under ALW. However, a qualified RN or social worker may be contracted or hired by the RCFE/ARF to provide necessary services to participants based on the participant's individual service plan. Individual RNs and social workers may operate as a business to provide ALW services as a CCA provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDSS CCL

Frequency of Verification:

Annual

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:

Augmented Plan of Care Development and Follow-up

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Augmented Plan of Care Development and Follow-up is available to Tier's 4 and 5 and requires prior approval from DHCS to add to a participant's ISP. This service documents the need for additional, appropriate staff to have an increased level of contact with the participant and documentation of this need for increased level of contact must be maintained in the participant's case file. The Care Coordination Agencies (CCA) will be required to perform a systematic assessment of a participant's behavior that includes a description of their functional and dysfunctional behaviors, the circumstances under which identified behaviors are exhibited and the factors that should be taken into account when developing a programmatic response to the behavior(s) in addition to Care Management services. This assessment is followed by a behavior plan that includes developing a written behavior plan including the prescription and management of psychiatric medications; training personnel to implement the behavior plan; monitoring the effectiveness of the behavior plan; and modifying the plan as necessary. The written behavior plan shall identify those participants who need more structured approaches to address challenging behaviors (such as Residential Habilitation Services). CCAs shall develop the behavior plan and monitor the effectiveness of the plan through periodic observation and assessment, and modify the plan as needed.

The CCA shall work closely with the County Mental Health plans and services to coordinate mental health services and ongoing medication management. The increased level of contact with the participant and coordination with County Mental Health is expected to require approximately twice the contact and assistance as persons who receive routine care coordination.

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

Service Assessment/Plan of Care Development ($320) may be billed in addition to "Care Coordination" for those participants that require the services as listed above. This service will be reimbursed per month, based on prior authorization as outlined on the ISP.

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 Coordination Agency (CCA)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Augmented Plan of Care Development and Follow-up

Provider Category:

Agency

Provider Type:

Care Coordination Agency (CCA)

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Other Standard *(specify):*

Care Coordination Agency
Minimum Requirements for Care Coordination Agency (CCA)
Agency Experience and Staff Requirements

A Care Coordination Agency must employ the following staff with the required years of experience providing care coordination, which includes the following activities: conducting assessments, developing care plans, arranging for and monitoring service delivery, maintaining progress notes and case records, conducting quality assurance reviews, and collecting data.

Registered Nurse (RN):
A RN must have and maintain a current, unsuspended, un-revoked license to practice as an RN in California and have work experience that includes either a minimum of 1,000 hours in an acute care hospital or a minimum of 2,000 hours of experience in a home health setting.

A Social Worker must have either a bachelor or master degree in social work, psychology, counseling, rehabilitation, gerontology, or sociology plus one year of related work experience.

Agencies must have mandatory annual in-service training programs for their staff. In-service training must include training on the HCB setting requirements at 42 CFR 441.301(c)(4)-(5), person-centered planning, and how to properly complete the ISP.
Agencies must have a process for soliciting and/or obtaining feedback from clients regarding their satisfaction with service.
Agencies must have a quality assurance program to track client complaints and incident reports.
Agencies must maintain a service record for each client. At a minimum, the record must contain all required forms, completed assessments, signed care plans (ISPs), and progress notes. Agencies must agree to make these records available to DHCS for audit.
Agencies must have contingency plans to deliver services in the event of a disaster or emergency.
Staff must agree to collect data as specified.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS upon application as an ALW provider and during annual review

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

NF Transition Care Coordination

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This benefit is designed to address the increased need for Care Coordination prior to the successful transition of an individual from a nursing facility (NF) into an assisted living setting. The Care Coordinator may claim the NF Transition Care Coordination reimbursement after the successful transition of the participant from a NF, NF subacute or acute facility into the ALW and establishment of residence in an assisted living setting.

The services must be rendered in the timeframe not to exceed 180 consecutive days prior to transition, and the services rendered by the Care Coordination Agency (CCA) must be consistent with the definition of transition services.

This one time reimbursement is intended to provide the sufficient hours for this transition to occur. It is a one-time benefit per participant with a calculation of the service rate being the equivalent of 5 months of care coordination.

The goal is for 60 percent of all waiver enrollees to transfer from a NF, NF subacute or acute facility in to the ALW. However, any individual who qualifies for the waiver may be admitted provided enrollment capacity is available.

• The specific services rendered prior to NF transition are as followed:
• Explanation of the ALW and alternative choices available to the participant
• Determination of Medi-Cal eligibility
• Administration of the Assessment Tool to determine tier at level of care
• Provision of information regarding available facilities
• Development of the ISP
• Submission of all documents to the DHCS for approval
• Upon confirmation of approval, coordination of transition of participant into chosen facility

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

This ALW benefit may be incurred once in the lifetime of the participant.

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 Coordination Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: NF Transition Care Coordination

Provider Category:

Agency

Provider Type:

Care Coordination Agency

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Other Standard *(specify):*

Care Coordination Agency
Minimum Requirements for Care Coordination Agency (CCA)
Agency Experience and Staff Requirements

A Care Coordination Agency must employ the following staff with the required years of experience providing care coordination, which includes the following activities: conducting assessments, developing care plans, arranging for and monitoring service delivery, maintaining progress notes and case records, conducting quality assurance reviews, and collecting data.

Registered Nurse (RN):
A RN must have and maintain a current, unsuspended, un-revoked license to practice as an RN in California and have work experience that includes either a minimum of 1,000 hours in an acute care hospital or a minimum of 2,000 hours of experience in a home health setting.

A Social Worker must have a either bachelor or master degree in social work, psychology, counseling, rehabilitation, gerontology, or sociology plus one year of related work experience.

Agencies must have mandatory annual in-service training programs for their staff. In-service training must include training on the HCB setting requirements at 42 CFR 441.301(c)(4)-(5), person-centered planning, and how to properly complete the ISP.

Agencies must have a process for soliciting and/or obtaining feedback from clients regarding their satisfaction with service.
Agencies must have a quality assurance program to track client complaints and incident reports.
Agencies must maintain a service record for each client. At a minimum, the record must contain all required forms, completed assessments, signed care plans (ISPs), and progress notes. Agencies must agree to make these records available to DHCS for audit.
Agencies must have contingency plans to deliver services in the event of a disaster or emergency.
Staff must agree to collect data as specified.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS

Frequency of Verification:

Annually

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Care Coordination Agency RN staff

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):

Prior to issuing a license the Department of Social Services (DSS), Community Care Licensing (CCL) is responsible for conducting a criminal record review of the applicant, administrator or any other adult involved in the operations of a licensed facility including all individuals working, residing or volunteering in a that facility and has the authority to approve or deny a facility license, or employment, residence, or presence in an RCFE/ARF, based upon the results of such a review. As part of the criminal records review DSS requires all individuals to submit fingerprints that are submitted to both the California Department of Justice and the FBI. All staff must be cleared prior to initiating participant/patient contact. Documentation of criminal record clearances and fingerprinting must be maintained by the facility and be available for inspection by DSS. DSS may seek verification from a law enforcement agency or court if it is deemed necessary.

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:

All RCFE/ARFs in the catchment area (county boundaries) are eligible to apply to be a waiver provider. The RCFE/ARFs complete a two-page application and submit it to the DHCS. The DHCS submits the facility information to the CCL to ascertain if the facility is regarded to be in substantial compliance and good standing in all licensing and certification requirements. If CCL recommends the facility, the facility is notified in writing. The letter advises the facility of the next steps to applying to be a Medi-Cal provider.

All HHAs wishing to work in the catchment area are eligible to apply. The HHA completes a two-page application and submits it to the DHCS. The DHCS submits the HHA information to L&C for a recommendation on the status of the HHA. The DHCS issues a letter advising the HHA of the next steps for applying to be a Medi-Cal provider. The DHCS works cooperatively with the local housing authorities in each county to identify and partner with an HHA to implement the PSH portion of the ALW.

HHAs, Non-profit organization, individuals or other case management business may apply to ALW to become a Care Coordination Agency.

Providers can access provider enrollment information through DHCS' Provider Enrollment Division: https://www.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:
Qualified Providers – The number and percent of ALW facility providers who did not allow their licensure and/or certification to lapse. Numerator: Number of ALW facility providers who continuously meet licensure and/or certification qualifications as verified during the regularly scheduled onsite monitoring reviews. Denominator: Number of providers that received onsite monitoring reviews in the waiver year.

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: CCL and L&C	☐ **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: CCL and L&C	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of enrolled ALW facility providers who are qualified to provide waiver services. Numerator: Number/percent of ALW facility providers enrolled in the waiver year, verified to have met all qualifications to provide waiver services. Denominator: Number of ALW facility providers enrolled in the waiver year.

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: CCL and L&C	☐ **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: CCL and L&C	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Qualified Providers Number/ percent of enrolled HHA providers who did not allow their HHA provider qualifications to lapse. Numerator: number of HHA providers who continuously met the specific provider qualifications of meeting the

participantsADL and IADL needs. Denominator: the number of HHA providers

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-Assurance: The State 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:
Provider Training - The number and percent of enrolled ALW facility providers who had mandatory in-service training programs for their staff as verified during regularly scheduled onsite monitoring reviews. Numerator: Number of providers who held mandatory in-service training programs for their staff.
Denominator: Number of providers who received an onsite monitoring review in the waiver year.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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 employs the following strategies to identify problems within the waiver program: conduct annual reviews to inspect participant and provider files, interview participants and providers, inspect physical plants and review waiver expenditures in accordance with the state's responsibility to provide oversight over its contracted entities separate from the reviews conducted by the Coordinated Care Agency and Community Care Licensing. DHCS provides continuous and ongoing TA to all waiver providers. This assistance includes clinical input, provider requirements, assistance with billing and significant issue documentation. The DHCS provides extensive training for new waiver providers including a manual specific to provider type. The DHCS conducts a biennial QA audit and review. The data from the review are aggregated and presented back to the providers in the format of TA. New strategies for improving waiver implementation are fostered by this process.

b. Methods for Remediation/Fixing Individual Problems

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

The DHCS identifies individual problems that are specific or unique to a single provider and addresses the problems directly with the provider. The nature of the issue and the severity of the problem are identified and discussed with the provider by the DHCS.

A Corrective Action Plan (CAP) or remediation process is developed by DHCS in conjunction with the provider to respond to the issue. The DHCS then monitors the provider with supportive TA to assure that resolution occurs.

If the issue continues, further TA with a more stringent CAP is developed. Providers may be placed in suspension from admitting and retaining additional waiver participants until the issue is resolved. The CAP period is between 30 calendar days to 180 calendar days depending on the nature and severity of the problem/finding. DHCS has sole discretion to determine the number of CAPs issued and duration period for each CAP hereunder, and this option is conditioned on the finding that DHCS determination is conclusive and binding.

In the event that the issue continues, or grows in proportion, the provider is disenrolled as a waiver provider and participants are moved to another provider site for continuity of care.

The participants are provided with a list of participating facilities within the county from which to choose. The CCA responsible for the participants would be the lead agency for assuring that the participant's freedom of choice is respected.

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: CCL and L&C	☐ **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.

The state's description of settings where waiver participants reside and receive HCBS demonstrates how the state will ensure that all HCB setting requirements at 42 CFR 441.301(c)(4)-(5) will be met and includes:

- A list of the specific settings where individuals will reside;
- A list of the specific settings where individuals will receive services;
- The process that the state Medicaid agency used to assess and determine that all waiver settings meet the HCB settings requirements; and
- The process that the state Medicaid agency will use to ensure that all settings will continue to meet the HCB settings requirements in the future.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Service Plan (ISP)

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.

The Care Coordination Agency (CCA) provides support on such things that would assist the participant with being successful in the program. Such supports include, but are not limited to, educating members and their representatives about ALW program criteria, obtaining available resources in the community, providing direction of the coordinated care, determining frequency of needed services, etc. In addition, the CCA is required to engage participants in the service plan development process to ensure all needs are addressed, including waiver services and personal/community needs. The Individualized Service Plan (ISP) is a participant-directed plan that identifies the services needed by the participant to assure health and safety in the assisted living or the assisted care settings. A participant has the authority to include individuals of his/her choice to participate in the service plan development process. The participant has the freedom of choice to select providers, including the CCA. During development of the ISP, individuals of the participant's choice, representatives from the residential care facility or the home health agency, and the care coordination agency can offer support and guidance to the participant. Each of these individuals and/or entities can offer a unique perspective to ensure the participant's plan for long-term services and supports is personalized to his or her specific needs.

The participant signs the ISP and indicates he/she was active in the development of the ISP and agrees or disagrees with any portion of the ISP as developed. The goals of the ISP are based on the 6-month interval until the subsequent reassessment.

The ISP also identifies any known issue, intervention and outcome of identified issues. The issues are defined in nursing/health care language and are not medical diagnoses.

The intent of identifying issues for the participant is to lead to a timely resolution of those issues by setting goals for remediation. An accurate goal is measureable and definitive, not vague as to time and manner of resolution. The intervention is the specific action that will be taken to achieve the goal. The outcome is the result of the intervention. If the outcome is not the resolution of the issue, then the issue continues to be an active issue on the ISP. When issues are resolved, the resolution is documented as the outcome, and the issue is subsequently inactive on the ISP. The ISP reflects the current needs of the participant and includes short-term goals that are resolved in the first six months, as well as long-term goals that persist on the ISP until eventual resolution.

The advocates for the participants involved in the ALW have stated a strong preference for the ISP to reflect the individualized needs of the participant. CCAs are to refrain from the use of repetitive language common to all ISPs but rather ensure that the ISP accurately reflects the current needs of each participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The ISP is based on the needs identified by the ALW Assessment Tool, clinical records, professional assessments and the personal preferences of the participant. The CCA administers the Assessment Tool which determines participant eligibility for the waiver. The tool measures the need for assistance with ADLs and the need for assistance in one or more of the seven functional categories: Cognitive Patterns, Behavioral Symptoms, Continence, Communications, Medications, Skin Conditions, or Other Treatments. Based on the combined need for assistance in these areas, the tool calculates a level of care eligibility and tier of service for the participant.

The ISP is a plan describing the services rendered to the participant, the manner in which the services are delivered, and the desired outcome for each service. The ISP must include specification of the type of provider performing each service and the frequency and duration of each service. The ISP must also include person-centered planning and properly address the participant's goals and preferences. Participants may choose to be involved in all aspects of the design, delivery, and modification of their services. They have the right to decide when services are delivered, where services are delivered and how services are delivered.

The CCA will ensure that the ISP is completed during the initial meeting and reviewed (and updated as needed) every six months. On an ongoing basis, the CCAs, in collaboration with the participants, will also be responsible for ensuring the appropriate, timely delivery of needed services. This will be achieved through face-to-face meetings with the participant and/or responsible parties every month, and a review of participant records at each six-month reassessment. Participants may request a review of their ISP at any time. The CCA assessments and determinations of Medi-Cal eligibility are subject to verification by the DHCS. Every six months the CCA RN will reassess participants and determine with the participant what, if any, updates need to be made to the ISP. The CCA will assess the participant for health and safety issues. Any signs of abuse or neglect will be reported immediately to Adult Protective Services (APS), the DHCS, and, if the participant is residing in an RCFE/ARF, CCL. If the participant is residing in PSH, L&C shall be notified.

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 ISP identifies potential risks to the participants that could compromise the participant's health and safety or well-being in the assisted living or assisted care setting. These risks may be identified by the CCA, the participant, the participant's representative, or by the direct provider of the assisted living or assisted care services. The CCA, in conjunction with the participant, representatives and providers, details a plan to mitigate or minimize the risks as described. The participant has the right and obligation to express his/her concerns with both the identification of risk factors and the proposed strategies to address those risks.

The ISP shall also include a long-term plan for accessing emergency services in the event of catastrophic or wide spread emergency occurrences. The ISP plan shall reflect the mobility limitations specific to each participant.

The CCA is initially responsible for assisting the member when there are issues with service delivery. The state works with the CCA, facility staff, the member and member's family where applicable to bridge any gaps in the event of service delivery disruption that cannot be immediately addressed by the CCA. Participating ALW providers are required through regulation to have a back-up plan to ensure service delivery in the event of an emergency. These plans are checked during monitoring visits by DHCS to ensure compliance.

RCFE/ARFs and Home Health Agencies must have current, written emergency disaster plans which must include the following: contain a plan for evacuation, address elements of sheltering in place, identify temporary relocation sites, and identify detailed staff assignments in the event of a disaster or an emergency. The emergency disaster plan must be posted prominently in the facility and be available to emergency responders.

California Government Code sections 8550-8551 provide the authority for the State to develop the framework and processes to establish statewide emergency programs. In licensed residential care settings, the California Department of Social Services regulates processes for accessing emergency services; in public subsidized housing settings, processes for provision of emergency services conform to the federal Housing and Urban Development requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants have the choice of waiver providers before they are enrolled in the ALW. Individuals and/or family members interested in learning about the choice of waiver providers are directed to the Department of Health Care Services' website which lists "Long-Term Care Alternatives" for home and community-based service options where ALW providers are identified by location and service area.

The initial contact with potential participants includes a discussion of the CCAs available in the county of choice. The CCA presents the individual with a list and description of the RCFE/ARFs/PSHs in the county of choice with a discussion of the similarities and distinctions among them.

As an example, some participants prefer the larger RCFE/ARFs with more apartment-like units and a greater variety of residents, while some participants prefer the smaller, six-bed style RCFE/ARFs with a more homelike atmosphere. The CCAs are responsible for providing the participants with the information they require to make informed choices.

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):

Every ISP is submitted to the DHCS every six months accompanied by the assessment for review and approval. The CCA retains the original and provides the DHCS (as well as the direct service provider) a copy of the ISP.

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 Medicaid Agency maintains a copy.

The CCA as the Case Manager, maintains the original.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The CCA is responsible for the development of the ISP with approval from the DHCS. The ISP is implemented by the direct service provider as well as any additional supportive entities as identified. As an example, the participant may have a need to attend church services. The provider may be a volunteer from the church to provide a ride to and from services.

The CCA is responsible for the primary monitoring of the ISP implementation. During monthly visits and reassessments, the CCA ensures all waiver services and participants needs identified in the ISP are being furnished. This is accomplished through meeting with participants to identify if they are experiencing any issues with accessing services. In addition, monthly visits ensure the CCA develops a rapport with the RCFE/ARF/HHA providers, allowing for the regular exchange of information, identification of new risks and confirmation that all services identified in the ISP are being rendered. CCAs collect information during both their monthly visits and 6-month reassessments. CCAs keep individual case files that are part of the DHCS annual provider audit. Reassessments are submitted to DHCS every 6 months. Problems identified during the monthly CCA visit are reported immediately to DHCS. DHCS and CCAs work together to monitor serious incident activity and resolution. To ensure compliance the CCA can adjust the ISP (if necessary). *The CCA is responsible for ensuring copies of the most recent ISP along with the RN assessment, Informing notice, Freedom of Choice, and amenity form are provided to the RCF/ARF and HHA where the participant resides. The RCF/ARF and HHA must maintain copies of these documents and ensure they are available for review upon request by the participant and DHCS at all times.*

DHCS provides additional monitoring and oversight through regular contact with all providers as well as biennial QA reviews. The biennial reviews require that DHCS staff visit the CCA offices as well as RCFE/ARF and PSH sites. The biennial QA audits include the Participant Experience Survey (PES) to ensure that the participants are satisfied with their overall delivery of waiver services.

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:
Individual Service Plan (ISP): Number/percentage of participants with an ISP that reflect the participants needs as identified by the assessment, clinical records, professional assessments and the personal preferences of the participant. Numerator: Number/percent of case files that reflect the participants' needs as identified. Denominator: Number of case files reviewed.

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants whose service plans were updated/revised to address a participants' changing need. Numerator: Number of case files that reflect updates to the participants' needs as identified. Denominator: Number of case files reflecting reassessments.

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

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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:
Timely Submission of the Individual Service Plan (ISP) – Number/percent of participant files reflecting ISPs submitted within 10 days after the completion of the assessment. Numerator: Number of participants case files with ISP submitted timely. Denominator: Number of case files reviewed.

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

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

CCA		
	☐ **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:
Number and percent of waiver participants whose service plans were updated/revised to address a participants' changing need- Numerator: Number of case files that reflect updates to the participants' needs as identified. Denominator: Number of case files reflecting reassessments.

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:
	☐ **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:

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:
Services Delivered according to type, scope, amount, duration and frequency identified in ISP - Number/percent of participants with services delivered in accordance to ISP Numerator: Number of facility case files with documentation that services were delivered according to type, scope, amount, duration and frequency identified in ISP. Denominator: Number of facility case files reviewed.

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

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

		Interval = 95% confidence +/- 5%
☒ **Other** Specify: CCA	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Participants are offered a choice between waiver services and institutional care –Number/ percent of participants with a documented choice between waiver services and institutional care. Numerator: number of participants whose Freedom of Choice document is signed, dated and in the CCA chart. Denominator: a representative number of 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 =
☐ **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.

The DHCS will compile a biennial QA Audit and Report summarizing the data and the findings regarding the LOC determinations. These findings are presented to the CCAs (also to the RCFE/ARF and HHA providers) by the DHCS. The DHCS is responsible for the identification and prioritization of issues as presented. The CCAs are responsible for remediation of those issues, and the efficacy of this process by the documentation of all findings and their remediation in the subsequent assessment submission period.

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 and when it is determined that the quality assurances are not being met, the DHCS will collect the data, aggregate the data, and present the findings to the providers with systems design change to correct and remediate the identified issues.

The DHCS will provide these data and changes in a TA format for all concerned providers.
The DHCS will also continue to provide direct TA to providers on a continuous basis as requested and when it is identified that there is a specific need for a given provider.

Remediation:
Within 60 calendar days of discovery, any non-compliance will result in the DHCS contacting the provider to:
• review the data;
• determine etiology of non-compliance;
• develop CAP with timeline;

Resolution Follow-up:
The DHCS will:
• follow up to determine if the CAP was completed with successful outcome;
• monitor the change(s) for continuing compliance;
• determine etiology of non-compliance;
• develop CAP with timeline.

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.

The CCA is responsible for explaining to individuals, or their legal representative, the services offered through the waiver. CCAs can help individuals make decisions about their choices of living arrangements by explaining the differences between receiving long-term services and supports in a nursing facility and in an RCFE/ARF or public subsidized housing setting. The CCA is also responsible for informing individuals about resources available to them to determine financial eligibility for long-term services and supports.

The Care Coordination Agency Provider Handbook is available to download from the Department of Health Services' ALW internet home page. The handbook provides guidance to ensure that:

• Potential participants, their legal representatives, relatives, or involved persons are informed of the choice of either participating or not participating in the ALW program, if the beneficiary is determined to be eligible for the ALW.

• Individuals are informed regarding the ALW's informal grievance procedures and formal appeal rights, termination procedures, and rights to refuse or discontinue services.

• There is an understanding that it is the Department of Health Care Services' responsibility, when an individual is denied waiver services, or when waiver services are reduced or terminated, to forward a Notice of Action (NOA) to the individual, or his/her legal representative. The NOA contains an explanation for the reason the State is denying, reducing, or terminating services, and provides information on how to ask for a State Hearing, and how to get questions answered, including telephone numbers for free legal aid.

• The individual's choice is documented on the Freedom of Choice document.

State Hearings are coordinated and conducted by the California Department of Social Services. Final authority for the adoption of decisions rests with the Director of the Department of Health Care Services, as per Delegation Order #94-151.

California will fully comply with the requirements of 42 CFR Part 431, Subpart E. Fair hearings will be conducted through the Medicaid Fair Hearing process. Notices of Action are issued in compliance with the CCR §51014.1 (Fair Hearing Related to Denial, Termination or Reduction in Medical Services).

Notice of Action (NOA) Process:

Upon denial of initial enrollment into the ALW program, or when a service has not been approved as requested, is reduced, terminated, or denied, DHCS will issue a NOA, "State Fair Hearing Notice Request" form, and the informational letter "Your Right to Appeal the Notice of Action." The NOA, hearing request form, and the informational letter are mailed to the participant or his/her legal representative/legally responsible adult(s) by DHCS.

In the event of a reduction or termination of continuous and previously authorized services, the DHCS mails the NOA, hearing request form, and informational letter to the participant and/or his/her legal representative/legally responsible adult(s), the participant's current primary care physician, and the waiver service provider within 10 calendar days of the effective date of the action.

The NOA advises the participant of DHCS' decision and the reason(s) to: 1) terminate or deny waiver enrollment; 2) reduce or terminate previously authorized waiver services; or 3) deny new or previously authorized waiver services. The NOA includes instructions advising the participant and/or his/her authorized representative(s) on how to request a State Fair Hearing before an Administrative Law Judge (ALJ). The participant must request a State Fair Hearing within 90 calendar days after the date the NOA is mailed to the participant.

If the request for a State Fair Hearing is submitted to the DSS Hearings Division prior to the expiration date printed at the top of the NOA, or within ten (10) calendar days of the date of the notice, the participant's waiver enrollment and/or previously authorized services will continue without interruption. The participant and/or his/her legal representative/legally responsible adult(s) are responsible for submitting the request for a State Fair Hearing before the action takes place. A copy of the NOA and the fair hearing request form is filed in the participant's case record maintained by DHCS.

State Plan and waiver services unaffected by the NOA will continue to be provided as authorized. The participant's Medi-Cal eligibility is not affected by a NOA, unless the NOA was issued because the participant no longer met the waiver requirements or LOC, the participant obtained his/her Medi-Cal eligibility through the waiver's income and resource eligibility requirements, or the participant no longer met regular Medi-Cal eligibility requirements.

State Fair Hearing Process:

Upon request of a State Fair Hearing, DHCS staff will contact the applicant or participant and/or his/her legal representative/legally responsible adult(s) to provide them with additional information on the State Fair Hearing process, and advise them they will receive DHCS' written position statement before the scheduled hearing date. If the participant and/or his/her legal representative/legally responsible adult(s) have not identified legal representation, DHCS will refer the participant and/or his/her legal representative/legally responsible adult(s) to the toll-free phone number on the back of the NOA for information regarding hearing rights, free legal aid, and information regarding Protection and Advocacy, Inc. DHCS will continue to work with the participant and/or his/her legal representative/legally responsible adult(s) to resolve the hearing issues before the scheduled date of the hearing. If a hearing is held and the DHCS Director's Decision upholds DHCS' action to reduce, terminate, or deny continued enrollment in the waiver and/or a waiver service(s), any aid paid pending the participant had been receiving will stop.

The participant may request a rehearing. Instructions on how to request a rehearing, and the grounds upon which a rehearing can be requested, are included with the ALJ's written decision. To request a rehearing, the participant must mail a written request to the address indicated in the instructions within 30 calendar days of the final decision. The participant must state the date the decision was received and the reason(s) why a rehearing should be granted. A request may be granted if the participant submits evidence that was not reasonably available at the time of the hearing that could change the outcome of the original decision. The Director may deny the request, or order the ALJ to conduct a rehearing on one, several, or all issues that were presented for review in the original State Fair Hearing.

If the participant is unsatisfied with the outcome of the original hearing or rehearing, s/he can elect to seek judicial review by filing a petition in Superior Court within one year of receiving notice of the final decision adopted by the DHCS Director. The participant may file this petition without first requesting a rehearing.

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).

The RCFE/ARFs and are required to submit Serious Incident Reports (SIR) to CCL as per Title 22. For the purposes of the ALW, the RCFE/ARF and HHA providers are required to submit a SIR to the CCA and DHCS within 24 hours of occurrence. A routine SIR may be submitted within 72 hours.

CCR Title 22§ 87211

a) Each licensee shall furnish to the licensing agency such reports as the Department may require, including, but not limited to, the following:

1) A written report shall be submitted to the licensing agency and to the person responsible for the resident within seven days of the occurrence of any of the events specified in (A) through (D) below. This report shall include the resident's name, age, sex and date of admission; date and nature of event; attending physician's name, findings, and treatment, if any; and disposition of the case.
(A) Death of any resident from any cause regardless of where the death occurred, including but not limited to a day program, a hospital, en route to or from a hospital, or visiting away from the facility.

(B) Any serious injury as determined by the attending physician and occurring while the resident is under facility supervision.

C) The use of an Automated External Defibrillator.

(D) Any incident which threatens the welfare, safety or health of any resident, such as physical or psychological abuse of a resident by staff or other residents, or unexplained absence of any resident.
(2) Occurrences, such as epidemic outbreaks, poisonings, catastrophes or major accidents which threaten the welfare, safety or health of residents, personnel or visitors, shall be reported within 24 hours either by telephone or facsimile to the licensing agency and to the local health officer when appropriate.
(3) Fires or explosions, which occur in or on the premises shall be reported immediately to the local fire authority; in areas not having organized fire services, within 24 hours to the State Fire Marshal; and no later than the next working day to the licensing agency.

DHCS requires RCFE/ARFs and HHAs to submit incident reports to the CCA and DHCS within 24 hours of occurrence for serious incidents or issues, or 72 hours for less serious issues.
1. CCAs e-mail incident reports to the state via a dedicated e-mail box (ALWP.IR@dhcs.ca.gov) which can only be accessed by the ALW Unit staff.
2. Incident reports are reviewed by ALW RN staff.
3. ALW RNs follow up with CCAs as needed.
4. The ALW team informs the California Department of Social Services Community Care Licensing Division when it has been determined that an RCFE/ARF is restricted from enrolling additional waiver participants.
5. Incident report data is entered into a spreadsheet for tracking purposes and analyzed for trends on an annual basis. DHCS tracks incident reporting activity in the ALW database. The date, type and disposition of the incidents are tracked on a continuous basis.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The CCA will be responsible for participant training and education. The CCA will discuss with and provide the participant with information regarding abuse, neglect, or exploitation; how to recognize if any of these occur; and whom to contact to report such events/incidents. The CCA will provide additional training as necessary. The CCA is a mandated Adult Protective Services (APS) reporter.

The RCFE/ARF is mandated to post the contact information for the Ombudsman in the facility. The CCA conducts an independent quality assurance visit monthly with the participant and completes a reassessment every six months.

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.

The RCFE/ARF and HHA are required to send a SIR to CCL or L&C within 24 hours respectively. The CCA forwards the SIR to the DHCS.

DHCS will investigate when the waiver provider fails to:
• Report abuse or neglect of a waiver participant;
• Notify the physician of a change in the participant's condition, if the participant is harmed by the failure of this action;
• Inform the participant of their rights;
• Provide waiver services as described in the participant's ISP;
• Provide adequate notification to the participant when services are changed or terminated;
• Act within their professional scope of practice (if verified, L&C will re-direct to licensing entity);
• Report suspected or verified medication misuse.

Within 30 calendar days of the identification of a trend or pattern of critical events, the provider will be given TA as the nature and severity of the issue. The DHCS will follow up within the next 30 calendar days to assure that the issue is ameliorated. In the event that the problem persists, the DHCS will issue a CAP with a 60-90 calendar day timeframe for remediation. In the event that the provider is unable to fulfill the conditions of the CAP, the provider will be suspended from further waiver enrollment and disallowed from enrolling additional waiver participants. In the event that the provider continues to fail to assure the health and safety of the participants, the DHCS will work in conjunction with CCL, L&C or Medi-Cal Provider Enrollment in the consideration of suspension of the RCFE/ARF, HHA license or suspension of a CCAs Medi-Cal billing privileges.

DHCS will notify the participant, their family or representative of any investigative results within 24 hours of completion of any investigation.

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.

The CCA is the first line of quality assurance and is responsible for intervening in the behalf of the participant in the event of a significant event. The SIR is submitted to L&C (HHAs) or CCL (RCFE/ARFs). CCA's are to submit all incident reports effecting health and safety to the following DHCS email, ALWP.IR@dhcs.ca.gov within 24 hours of a serious incident or 72 hours for less serious incidents. DHCS then reviews, logs, and downloads the report to the beneficiary's profile in the MedCompass data collection system. Reports for any period can be run by DHCS using MedCompass. Beneficiaries with an incident report in the system will populate on the report. The dedicated email box is monitored daily for all incoming incident reports. DHCS and CCAs work together to monitor serious incident activity and resolution. The DHCS Compliance Unit checks for compliance issues regarding documentation and submission timeliness during the annual provider visits.

The DHCS follows up with the CCA to monitor remediation and prevention of further similar events for the participantas indicated above.

In the event that the provider continues to demonstrate the inability to meet the requirements of a waiver provider, the provider shall be disenrolled as a waiver provider and the participants transferred to another locale within 30 days as per CCL.

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 Department of Social Services Community Care Licensing Division (CCLD) under the authority of the Health and Safety Code and California Code of Regulations Title 22 (22CCR) Section 80072 states, "(a) Except for children's residential facilities, each client shall have personal rights which include, but are not limited to, the following: (8) Not to be placed in any restraining device." The use of restraints in Community Care Facilities is prohibited. The State law requires theCCLD to conduct unannounced annual inspections of RCFEs and ARFs, unannounced complaint inspections, and may conduct unannounced random visits as a follow-up to incidents or when the CCLD is concerned about the health and safety of residents. The facility administrator must be present and available within 30 minutes at all times. In the event the administrator is not available they must designate a qualified person to serve as the back-up administrator. This person must have the knowledge and ability to perform all the duties required of the administrator. Additionally, depending on the severity of any violation(s) that result in deficiencies, civil penalties and/or action by the Department against the license and to the licensee.

The use of chemical restraints is prohibited unless otherwise prescribed by the treating physician. Chemical substances that restrict the freedom of movement, subdue, sedate, or restrain a resident must be prescribed by a physician. The CCA must clearly document and explain the purpose and intended use of the chemical restraints in the ISP. The CCA is also responsible for monitoring the administration of the chemical restraints.

○ **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:

DSS CCL is the licensing and regulatory authority for the RCFE/ARF. CCL enforces the regulatory language prohibiting unlawful restraints. CDPH L&C is responsible for the regulatory management and oversight of the HHA. L&C enforces the regulatory language regarding unlawful restraints.

The Department of Social Services Community Care Licensing Division (CCLD) under the authority of the Health and Safety Code and California Code of Regulations Title 22 (22CCR) monitors the health and safety of residents by conducting unannounced annual inspections, unannounced complaint inspections, and may conduct unannounced random visits as a follow-up to incidents or when the CCLD is concerned about the health and safety of residents. Additionally, depending on the severity of the violation(s) that result in deficiencies, civil penalties and/or action by the Department against the license and to the licensee.

○ **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 monitors the use of exclusion through review of the Individualized Service Plans (ISPs), during biennial Quality Assurance site visits, and through the Utilization Review process.

The Department of Social Services Community Care Licensing Division (CCLD) under the authority of the Health and Safety Code and California Code of Regulations Title 22 (22CCR). The use of seclusion in not allowed in community care facilities. Should the practice of seclusion be found during an inspection or via compliant would result in a violation of a resident's personal rights to be free of involuntary seclusion per Section 87468. Additionally, depending on the severity of the violation(s) that result in deficiencies, civil penalties and/or action by the Department against the license and to the licensee.

○ **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.

The RCFE/ARF is responsible for medication management for the participants unless the participant has a physician order to self-manage his/her medication(s). Medications are maintained in the Medication Room of the RCFE/ARF and accessed only by the designated staff. The oversight and management of medications is under the auspices of the CCL.

In the PSH setting, the participant has responsibility for the maintenance and safeguards of his/her medication. The HHA will assist or administer medications by licensed staff as necessary.

As of January 1, 2019, the Community Care Licensing Division's (CCLD) Adult and Senior Care Program (ASCP) is mandated to conduct annual visits to all Community Care Facilities, including Residential Care Facilities for the Elderly (RCFE), including those participating in the ALW. CCLD will review medications during the unannounced annual inspection, during random unannounced inspections, when medications are involved during a complaint investigation, and whenever CCLD is concerned about the health and safety of residents as it pertains to medications.

The Department of Social Services Community Care Licensing Division (CCLD) under the authority of the Health and Safety Code and California Code of Regulations Title 22 (22CCR) monitors the health and safety of residents by conducting unannounced annual visits, unannounced complaint investigations, and may conduct unannounced random visits as a follow-up to incidents or when the CCLD is concerned about the health and safety of residents. Additionally, should a violation of 22CCR be found, the licensee shall receive a deficiency, which may result in civil penalties.

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.

In the RCFE/ARF setting, the state oversight is provided by the CCA staff. The CCA provides a QA component with the CCA RN review of medications during the semi-annual assessment.

CCL employs Licensing Program Analysts (LPAs) to inspect and regulate the RCFE/ARF. The LPAs inspect the medication room and ensure that the providers are compliant with the regulations governing the storage, administration and documentation of medications. The CCA monitors to ensure that the participants are receiving their medications as per the physician's orders.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The RCFE/ARF utilizes medication technicians to assist participants with medications, but the technicians may not administer medications. Under California law, only a licensed nurse (or physician) may administer a medication.

The RCFE/ARF has the ability to assist participants to the extent of passing medications or opening syringes and handing them to the participant, but the participant must have the ability to self-administer the medication or the services of a licensed nurse are required. This requirement is enforced by CCL.

Under the ALW, both RCFE/ARF and HHA providers are required to have skilled nursing staff sufficient to meet the skilled nursing needs of the participant. If the participant is unable to take medication with assistance, the RCFE/ARF or the HHA is responsible for providing the licensed nurse as needed.

As of January 1, 2019, the Community Care Licensing Division’s (CCLD) Adult and Senior Care Program (ASCP) is mandated to conduct annual visits to all Community Care Facilities, including Residential Care Facilities for the Elderly (RCFE), including those participating in the ALW. CCLD will review medications during the unannounced annual inspection, during random unannounced inspections, when medications are involved during a complaint investigation, and whenever CCLD is concerned about the health and safety of residents as it pertains to medications.

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:

The RCF reports to the CCL and the HHA reports to the L&C.

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

All medication errors are recorded.

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

All medication errors are reported.

○ **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.

The RCFE/ARF reports to the CCL and the HHA reports to the L&C.

CCL visits all of the RCFE/ARFs participating in the ALW annually. DHCS visits the RCFE/ARF annually.

The HHA is visited annually by L&C.

When CCLD issues a deficiency or conducts a visit, a report must be given to the licensee for records and for posting in the facility. Once a report is issued, it uploaded to their transparency website, which is refreshed weekly. DHCS is registered for ALW facilities so an automatic updates is sent to DHCS whenever a report is uploaded. In addition, the DHCS is in communications with DSS about serious issues whenever the CCLD is taking an action on a facility. The Department continues to collaborate with the DSS on oversight activities in ALW RCFEs.

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:
Health and Welfare Number and percent of Serious Incident Reports (SIR) involving occurrences of abuse, neglect, or exploitation. Numerator: Number of SIRs involving abuse, neglect, or exploitation, resolved in the waiver year. Denominator: Number of SIRs involving abuse, neglect, or exploitation, reported to DHCS in the waiver year.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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 number and percent of cases reviewed with documentation CCA has recognizing instances of abuse, neglect or exploitation with the participant/other responsible person reflecting resolution. Numerator: Number of case files reviewed, in the current waiver year, with documentation that the CCA discussed how to recognize and report instances of abuse, neglect or exploitation with the participant/other responsible person. Denominator: Total number of case files reviewed in the waiver year.

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

Data Aggregation and Analysis:

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

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

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 number and percent of reviewed ISPs that do not include orders for use of unauthorized restraints or seclusion. Numerator: Number of case files reviewed, in the current waiver year, that do not include unauthorized use of restraints or seclusion. Denominator: Total number of case files reviewed in the waiver year.

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:

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measure:
The state monitors overall health care standards based on the approved waiver.
Numerator: Cases reviewed that meet standards. Denominator: Total 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 =
☐ **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.

The direct providers of the assisted living services are held accountable to assure the health and safety of all participants in their care. The CCA provides the framework for that assurance within the ISP. The CCA also conducts the monthly visit and reassessment every six months to assure that the needs of the participant are being met. The DHCS conducts a 100% review of the documents submitted and a biennial QA audit to assure that the health and safety of the participants is not jeopardized. The DHCS retains the authority to restrict enrollment to by any provider of whom there is a question or concern in this regard. The DHCS retains the authority to disenroll any provider who fails to respond to remediation and TA in this regard.
Discovery:
Monitoring/Prevention
The DHCS will annually review a random sample of CCA, HHA and RCFE/ARF files to verify documentation of continuous monitoring of:
• participant risk and risk management, preventative measures to assure health and safety as indicated by the ISP
• information provided regarding abuse, neglect and exploitation.

Abuse/Neglect
The DHCS will review the SIRs as submitted by the providers to verify that suspicion of or observed acts of abuse, neglect and exploitation were identified and immediate appropriate action was taken.

Incidents/Complaints
The DHCS will review the SIRs with L&C and CCL as appropriate.

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.

Remediation:
Monitoring/Prevention
• The DHCS will notify the provider upon discovery of failure to meet requirements for continuous monitoring and develop a corrective action plan.

Abuse/Neglect, Incidents/Complaints
• Immediately upon discovery of inappropriate or untimely action in response to a report, the DHCS will notify the responsible party to develop a corrective action plan.

Resolution Follow-up:
The DHCS will:
• Follow up to determine if the corrective action was completed
• Monitor the change(s) for continuing compliance.

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: CCL and L&C	☐ **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 ALW Quality Improvement Strategy (QIS) is designed to provide meaningful performance measures through the review of participant ISPs to identify all health care needs and develop prevention strategies through trend analysis, prioritization of assessed participant risks, and development of specific goals and objectives resulting in the implementation of system improvements.

The State assures quality of participant health and welfare by setting proactive quality improvement strategies with participation and collaboration of the CCA in tandem with participants and/or their families, providers, consumer/participant advocates, and local and state agencies. Agreed upon quality improvement goals are set on an annual basis with specified objectives. The State uses reported data to set ad hoc improvement goals as the data and circumstances suggest.

This approach is focused on the expectation that through comprehensive development of a participant's ISP, (which includes all measures of the ALW Assessment Tool - assistance with ADLs, IADLs as they relate to coordinated physical health and community-based supports and services, as well as the seven (7) functional categories of cognitive patterns, behavioral symptoms, continence, communications, medications, skin conditions and other treatments). Each ALW participant will have a greater likelihood of improved health status and quality of life. Concurrently, this process allows early identification and prevention of deterioration of the participant's intake health status while supporting the assurances of 42 CFR §441.301 and §441.302. The ALW uses the participant's ISP as a gauge to measure all health care needs and develop prevention strategies through qualitative analysis of the services delivered. The ISP focused preventions allow the ALW participants and providers to have a direct role in the quality assessment and quality improvement processes allowing timely interventions to assure early identification of health and welfare needs.

Access
The CCA is responsible for assessment of the participant for admission into the ALW.
The CCA is responsible for the following:

• Prior to the participant's enrollment into the ALW, complete the initial ALW Assessment and develop the initial ISP documenting the participant's initial health care needs.

• As stated in Appendix C-3, the ISP will include specified services to be provided with measureable outcomes for each service.

• The ISP will be updated as needed (at a minimum of every 6 months).

• The service performance measures are addressed by a regular review of the desired outcome of each health care need with the development of specific action plans if needed to improve or review the participant's health care needs.

• Each ISP review will assess the participant for health and safety needs, including any signs of abuse or neglect that will be immediately reported to APS, DHCS and the L&C.

Trending
• The DHCS tracks and monitors the following data sources:

• ISPs and SIRs from the RCFE/ARF and the HHA

• ISP updates to measure the effectiveness of updated and/or revised service plans

• Complaints or concerns voiced by the participants

• Concerns identified by the CCAs

• The ISPs and SIRs are tracked in a log and trended by provider and type of action.

Prioritizing

The ALW recognizes the following hierarchy of concerns:

1. Any ISP change, (as detailed in Appendix D) change in presenting health condition(s), altered care delivery goals, intervention needs, and measured outcomes to quantify compliance with waiver health and welfare assurances.

2. All SIRs, specifically;
   a. Events resulting in participant injury or accident;
   b. Events resulting in hospitalization or treatment;
   c. Immediate threats to health and safety;
   d. Potential threats to health and safety;
   e. Other health care concerns that may manifest under certain conditions.

Implementing

1. The DHCS biennial QA audits provides the data for TA to all ALW provider(s).

2. Identified ISP and SIR trends are closely monitored by the DHCS to support the assurances of 42 CFR §441.301 and §441.302.

3. For all assurance problems with providers the DHCS reviews the nature and severity of the problem and, if needed, develops a CAP as indicated for the provider in question.

4. The DHCS continues to monitor and follow up with the provider to ensure that the conditions of the CAP are met and the health and safety needs of the participant are met.

5. If the conditions of the CAP are not addressed, then probationary action is initiated.

The DHCS primary systems improvement objective for the QIS is to assure participant health and welfare through the following measures:

1. To identify, quickly and reliably, positive or undesirable trends that will allow for necessary adjustments to enhance overall performance of the system, and act on opportunities for improvement;

2. Assure data undergoes rigorous reliability and validity testing that is used to drive policy and procedure decisions to increase performance; and,

3. Ensure timely discovery and remediation that allows the DHCS to take swift action to improve meaningful outcomes for the participants in the ALW.

The QIS process is designed to review all participant reports, assessments, reassessments, special incident reports, critical incidents reports, etc. The following details how the ALW performs trend analysis and prioritizes areas in need of remediation.

The ALW Trending/Prioritizing/System Improvement Process:

The QIS will determine to what extent each waiver assurance has been met during the reporting period, measure it against ALW goals, and assess and prioritize trends towards the goal of implementing system improvements.

1. Aggregate data is collected for each performance measure. Measures include: participant assessments; reassessments; ISPs and SIRs from the RCFE/ARFs and the HHAs; complaints or concerns voiced by the participants and concerns as identified by the CCAs.

2. The ALW methodology is to coordinate the analysis of each performance measure, and track data by: participant, frequency, provider type, action, remediation, and systemic issues. Additional data review includes identification of health care needs based on enrollment primary diagnosis and reassessed changes in participant

health service tier.

3. The participant's LOC is reevaluated every 6 months. Trending of these data sources measures the provider's compliance with quality assurance and promotes identification of needed remedial or corrective actions. A combination of audit tools is used to support analysis of the performance measures.

4. CAPs are prioritized based on risk assessment and health and welfare needs of participants. Interventions include a continuum of actions from staff training to removal of provider from the ALW. All CAPs are monitored for efficacy of remedial action. The remedy/improvement may be more appropriately targeted to specific situations.

The DHCS primary systems improvement objective for the QIS is to assure participant health and welfare through the following measures:

• Identify, quickly and reliably, positive and adverse trends that will allow for necessary adjustments to enhance overall performance of the system, and act on opportunities for improvement;

• Assure data that is used to drive policy and procedure decisions undergoes rigorous reliability and validity testing to increase performance; and

• Ensure timely discovery and remediation that allows the DHCS to take swift action to improve meaningful outcomes for the participants in the ALW.

• Performance Measure Indicator: – All SIRs are followed up within 24 hours by the State and specific licensing agencies as provided in state regulations. Identified ISP and SIR trends are closely monitored by the DHCS to support the assurances of 42 CFR §441.301 and §441.302.

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: CCAs, RCFE/ARFs and HHAs	☒ **Other** Specify: On-going and continuous

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 Medicaid agency retains the ultimate authority for the assurance of quality and quality improvement in the ALW.

The QIS uses a multi-level approach. Each level is designed to promote discovery, identify trends and capture timely remediation information that promote system improvements.

Level One: Level of Care Evaluation/Reevaluation

• LOC determination as detailed in Appendix B-6 is generated by the CCA prior to initial enrollment and reviewed by the DHCS

• Each waiver participant is reassessed for LOC at least every six months or upon significant change by the CCA. All reassessments are reviewed by the DHCS.

• The ISP, jointly developed by the participant and the CCA, is used to guide all plan services and safeguards as detailed in the waiver guidance.

Level Two: Service Plan
• As detailed in Appendix C, the CCA reviews the ISPs monthly with the participant to assure that the participant's needs are addressed and considered.

• The ISPs are developed in accordance to the waiver requirements to identify all health care needs and address health and safety risks of participants, with monthly review by the CCAs and annual review by the DHCS.

• The ISPs are revised as needed and at least every six months by the CCAs and reviewed by the DHCS.

• Services outlined by the ISP are implemented by staff of the RCFE/ARFs and HHA, and reviewed monthly by the CCA and annually by the DHCS.

• Providers are held accountable for the health and safety of the participants. ISPs are reviewed for completeness and the appropriateness of the interventions for addressing the healthcare needs of the participant as identified in the assessment.

Level Three: Coordination of the Qualified Providers
• CDSS CCL is responsible for ensuring RCFE/ARFs meet licensing and certification requirements of the CDSS.

• CDPH L&C is responsible for ensuring that HHAs meet the licensing and certification requirements of the CDPH.

• DHCS is responsible for annual monitoring to assure provider adherence to waiver requirements, and follow up when providers have not met specified standards.

• DHCS is responsible for annually compiling and reviewing data collected from waiver providers and waiver participants for quality assurance.

• Providers are responsible for the health and safety of the participants.
The CCAs monitor the RCFE/ARFs and HHAs and the DHCS monitors the CCAs (as well as the RCFE/ARFs and the HHAs).

Level Four: Prevention of instances of abuse, neglect and exploitation
• Through the ALW Provider Manual and annual training, the State provides TA to the CCAs and all providers on the identification of abuse, neglect and exploitation, timelines for the notification of specified authorities, and remediation information.

• The State reviews all SIRs, with linkages to the State Licensing Agencies.

• The State analyzes a statistically significant percentage of SIRs for trends to allow development of risk prevention strategies. Data is reviewed continuously and analyzed annually by the DHCS.

• Systemic issues are addressed through CAPs and TA by the DHCS. The DHCS continues to monitor the providers after the deliverance of the TA to assure that the practices are changed according to the CAP and that the issues are remediated.

In the event that the systemic issues persist, the DHCS will revisit the provider, offer additional TA and impose sanctions as indicated and as described in H.1.a.i. TA is offered to the providers on a global basis for program-wide systemic issues and on an individual basis for issues pertaining to a particular provider.

Level Five: Administrative Authority provided by the DHCS
• DHCS is the administrative authority for the ALW that monitor actions of other State agencies and of all providers.

• The annual review of provider records and of participant records followed by monitoring and analysis produces the recommended changes brought to the QMS for discussion and action.

• The Olmstead Advisory Group and the ALW Stakeholders' Group provide input to the ALW quality management system. These advisory groups are comprised of primary customers and family members, providers, and advocacy organizations that meet quarterly.

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

The Medicaid agency retains the ultimate responsibility for the assurance of quality improvement through the implementation of the QIS. The process for periodic evaluation of the QIS is embedded in the biennial QA audit. The audits are based on the performance measures and are held to the standard of the confidence interval.

The QIS has a process that separates the programs measures into,
1) required actions taken, indicating that the provider has followed protocols and all corrective measures have been resolved, and

2) corrective actions taken by provider and reported to the QIS prior to audits and/or review of trend analysis.

Individual provider problems are based on review of State regulations and policies governing actions specified in licensing guidelines. As required by corrective action findings individual providers will complete specified staff trainings to update staff competencies based on ALW participant's needs.

The QIS documents all oversight activities through program letters, coordination of provider continued eligibility as a Medi-Cal contracted provider of ALW services, noted in all provider records, maintained in a running record in the providers files, and update reports to CMS as required.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Health Insurance Portability and Accountability Act (HIPAA) Compliant HCPCS Codes are unique to each waiver service. Each provider type is only eligible to bill for the wavier service(s)they render. The billing is via a standardized billing form,the UB-04. Claims are submitted to the fiscal intermediary for payment. Only recognized Medi-Cal billers may be paid for waiver services. Waiver service providers are not required to secure an independent financial statement audit.

A listing of ALW service rates are available at http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx

Audits are conducted at three levels:

1) The DHCS examines the provider records and contrasts and compares the records with the authorized services;

2) The Audits and Investigations Division (A&I) is available to conduct a more detailed financial analysis in the event of suspicious billing practices; and

3) The state conducts routine, random audits of all Medi-Cal billers to ensure competency and accuracy in the paid claims. These audits occur on an ongoing basis throughout the year.

A&I is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services. A&I conducts audits on an ongoing basis throughout the year. All claims submitted by waiver and state plan providers are subject to random review regardless of provider type, specialty, or service rendered. A&I verifies that claims selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional documentation may result in suspension from the Medi-Cal program, pursuant to W&I §14124.2. A&I has three branches that conduct reviews using various methodologies to ensure program integrity and the validity of claims for reimbursement.

A&I utilizes both desk reviews and on-site review processes when reviewing claims data. A&I conducts larger scale claims reviews through a desk review process to identify billing trends to flag for additional investigation. A&I will then do follow up focused desk review on specific providers and if claims discrepancies are identified can lead to onsite audit to compare billed/paid claims against services authorized and documented in the waiver participants' plan of care. A&I uses random sampling of claims for audit processes across all three levels of auditing described in the waiver application. A&I will run desk review queries that randomly sample claims submitted by specific provider types over specific time periods. Claims sample periods can vary based upon the objective of the audit but typically are set at intervals of six months or by fiscal years. The random sampling is dependent on the type of query run (ie. prov type, provider specific, billing code specific). A&I identifies a statistically significant sample size based upon the query and then generates a sufficient random sample for review.

ISCD monitors billing on a quarterly basis as well as focused queries prior to onsite visits in order to identify any potential billing issues. If issues are identified, ISCD will work with the fiscal intermediary and A&I to arrange ad hoc desk and onsite reviews to further investigate potential findings/inappropriate billing practices and recoup payment if determined necessary.

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 may 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.

The 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. Failure to comply with any request by A&I staff for documentation may result in administrative sanctions, including suspension from the Medi-Cal program, pursuant to W&I §14124.2.

MRB staff work closely with the fiscal intermediary 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. IB is also responsible for coordinating provider fraud referrals to the state Department of Justice (DOJ) and Federal Bureau of Investigations. Suspected fraud or abuse identified through any audit or investigation process is referred to the DOJ via the IB. IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. IB serves as DHCS' principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

The Department of Finance (Finance), consistent with its responsibility for serving as the Governor's chief fiscal policy advisor, is responsible for federal audit coordination. Finance assigns the Office of State Audits and Evaluations (OSAE) to perform the necessary steps to carry out the State's responsibilities

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:
Financial Accountability-Number and percent of participants who were enrolled on the waiver prior to submission of claims. Numerator: = number of participants who were enrolled on the waiver prior to submission of claims Denominator: = total number of waiver participants

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
1. DHCS Audits-provider records, contracts of authorized services 2. A&I conducts detailed financial analysis on all suspicious billing 3. State Medicaid Agency conducts random audits

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

(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 =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *As determined necessary*
	☐ ***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:* *A&I* *DHCS*	☒ ***Annually***
	☒ ***Continuously and Ongoing***

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

b. Sub-assurance: The state 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:
Financial Accountability - Number/percent of claims coded and paid for in accordance with the reimbursement methodology. Numerator: number of claims coded and paid in accordance with the approved rate. Denominator: number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
1. DHCS Audits-provider records, contracts of authorized services 2. A&I conducts detailed financial analysis on all suspicious billing 3. State Medicaid Agency conducts random audits

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***	☐ ***Annually***	☐ ***Stratified***

Specify:		*Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *As determined necessary*
	☐ ***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:* *A&I* *DHCS*	☒ ***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.*

Discovery:
An on-site qualification review will be conducted for all waiver providers to ensure provider qualification compliance.

The DHCS will annually review a random sample of paid claims data to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in Appendix I-3 of the approved waiver.

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.*

A representative sample size of paid claims data will be generated, based on the enrolled population, to ensure that claims are coded and paid for in accordance with the reimbursement methodology. In the event that a discrepancy is discovered, the provider would be given a plan for remediation, a timeframe in which to implement the changes in their billing practices as described in the plan to achieve the indicated improvement and then perfect design changes to ensure continuance of enhanced practice.

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).*

DHCS solicits comments from the public when a new rate methodology is being implemented or new rates are being developed. In most cases when adjusting Waiver rate methodologies, the rate methodology is presented through the standard public input process. The State publishes the Amendment/Renewal online for public review and input along with an electronic news blast to interested parties, and publishes a notice in the California Register to inform the public, through non-electronic means, that the rate methodology is changing and where the public can find a copy. In other cases, Waiver rates are tied to Medi-Cal State Plan rates, which are handled through the official DHCS SPA public noticing process. For example, updates to rates as a result of minimum wage increases. Lastly, DHCS informs stakeholders of the ALW through direct correspondence, website updates, and through bi-monthly stakeholder calls hosted by DHCS.

DHCS released the design and reimbursement structure of the ALW in a series of public stakeholder meetings in the summer of 2005. The original four tiers of service and the Care Coordination service remain cost neutral with the assumption that ALW participant use of state plan services does not generally exceed the predicted annual average for Factor D'.

The state used the hourly Medi-Cal rate for Homemaker, Home Health Aide, and Personal care to establish the Tier 1 baseline daily rate. The daily Tier 1 rate assumes roughly one hour spent providing those three services throughout the day. Additionally, the state factored an additional ~20% for fringe benefits paid to the facilities to account for standard employer costs for direct care workers.

The state assumes a 20% increase in service duration/engagement per client as each acuity level increases. The daily bundled rate for the ALW was developed through stakeholder input and comparable services for similar populations. Utilizing the ALW assessment tool to determine acuity level of participants, as well as comparing needs of those similar populations, acuity levels of participants are reasonably accurate in determining the number of hours of service needed per client. In other words, Tier 1 participants generally need roughly one hour per component provided intermittently throughout the day. As acuity levels rise, the state determined that the number of hours per component needed per client rose approximately 20%. The exception to these assumptions is in tier 5, which is reserved for the highest acuity participants with Traumatic Brain Injury (TBI). Stakeholders played a key role in determining the daily rate for this level of service. The Department and stakeholders agreed that the Tier 5 rate would be sufficient to fund qualified staff for these participants whose needs are significantly more intensive than the other acuity levels.

The new reimbursement structure, which includes the addition of Tier five was publicly presented through a stakeholder meeting held August 29, 2013 and reflects the severity of the physical, mental and cognitive condition of an individual with traumatic brain injury as an ALW participant. The increase rate for Assisted Living Services and the addition of Residential Habilitation and Augmented Plan of Care Development and Follow-Up will ensure appropriate care and supervision of all ALW participants.

The increased reimbursement rate for Tier five, Assisted Living Services is based upon the statewide weighted average NF-B rate.The statewide weighted average NF-B rate is divided into seven regions or "peer groups," all having a different daily weighted average rate. For ALW, DHCS averaged the rate in the most densely populated region (Los Angeles at $204.31/day) and the least densely populated region (includes Kern and Tulare at $193/day). The average daily rate of the two regions resulted in $199, rounded to $200 for the ALW.

The State arrived at the rate of $1,600 for NF Transition by estimating the amount of work necessary to transition an individual from a SNF into the waiver, within the limitations of cost effectiveness standards and yet still offering a financial incentive to Care Coordinators to actively pursue the NF transition. The figure of $1,600 is derived from the estimation that NF transition is the equivalent of five months of Care Coordination. Care Coordination is estimated to cost $320/month.

The rate for Augmented Plan of Care Development and Follow-Up is based upon the assumption that many participants will require approximately 11 hours per month of this type of service that would be reimbursed at the Medi-Cal home and community-based services waiver, home health agency case management rate of $11.36 per 15 minutes.

Residential Habilitation is a service designed to provide greater attention to ALW participants with violent or self-destructive behaviors. It provides specialized behavior modification techniques related to issues such as Traumatic

Brain Injury (TBI). The service pays for additional, appropriate staff to focus individual attention on one participant to assist in acquiring, retaining and improving the self-help, socialization and adaptive skills while concentrating on helping them to control their behavior issues that would otherwise preclude them from living in a community setting. Staff may be licensed medical staff, personal or nursing aides, security personnel, or other specialties as appropriate to the specific participant. The state considered the service definitions, provider qualifications and unit rates of similar HCBA and MSSP services when determining Residential Habilitation rates. DHCS used the average cost per user for this statutory service for the HCBS Waiver for Californians with Developmental Disabilities as the baseline, with an additional $0.25 per 15 minute increment to account for the potentially higher acuity participants of ALW who have TBI. The rate was developed with stakeholder input.

Care Coordination rate is based on case management rates paid for other HCBS Waivers, but is paid at a higher rate to account for the greater responsibility of ALW Care Coordinators. For example, ALW Care Coordinators are required to reassess each participant every six months, and more frequently if the participants' condition changes. Additionally, Care Coordinators are required to conduct face to face meetings with participants on a monthly basis. These requirements are more stringent than other HCBS Waivers, including MSSP which requires quarterly face-to-face visits and annual reassessments. Conversely, the ALW Care Coordination is less stringent than what is required in the AIDS Waiver, which requires a social worker and an RN case manager. DHCS used MSSP and AIDS Waivers as the baseline for determining the Care Coordination Rate. Staffing / provider qualifications, assessment/reassessment requirements, frequency of beneficiary contact, and other challenges specific to the Wavers' populations served all factored in to the development of the ALW Care Coordination rate. The Care Coordination rate also takes into account the annual increases in minimum wage, as there are clerical staff employed by the Care Coordination Agency. The Care Coordination rate paid to the CCAs ensures adequate payment for the specialized staff (RN with specific experience requirements, and Social Workers) as well as the clerical staff and other fixed costs of the CCA. The rate was developed with stakeholder input.

Tier five will continue to provide cost neutrality in the aggregate with the assumption that the use of State Plan services will not generally exceed the predicted annual average of $5,500.

All waiver participants will continue to receive the services they are entitled to through the waiver and the State Plan. This waiver will not violate the Medicaid comparability requirement that services must be comparable, and are based on medical necessity, not enrollment in another Medicaid program.

The Integrated Systems of Care Division holds direct responsibility for determining rates and for oversight of the rate determination process.

A list of all reimbursement rates are posted on the ALW website at: http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx and is reviewed at stakeholder meetings prior to implementation.

The State will release stakeholder notifications to inform providers/stakeholders of upcoming rate changes and the schedule for implementation. Service rates are posted on the ALW web page and updated upon change. The State also informs providers and stakeholders of any upcoming changes to service rates during bi-monthly stakeholder calls.

ISCD runs billing queries for a random audit sample prior to onsite visits. Results may trigger follow up questions and requests for additional documentation to confirm billing practices. These audits are performed monthly, but they are limited to the amount of cases audited by staff during site visits. ISCD also runs quarterly queries to fulfill waiver reporting requirements, and uses obtained data to also review for inappropriate billing incidents. This process will trigger ad hoc onsite visits if/when billing discrepancies are identified.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The waiver service providers bill Medi-Cal directly using the UB-04 standardized billing form.

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:*

All ALW participants have full-scope Medi-Cal eligibility with no share of cost.

The CCA confirms eligibility at the time a participant is enrolled by obtaining a Medi-Cal eligibility printout. The CCA continues to verify Medi-Cal eligibility monthly.

The CCA completes the Assessment Tool and verifies the NF LOC status of a potential participant. To enroll a participant into the ALW, the CCA forwards the enrollment forms for processing to the DHCS.

Claims submitted for each participant are processed through the California Medi-Cal Management Information System to check for Medi-Cal eligibility prior to payment.

DHCS will regularly review a random sample of paid claims to assure that claims are coded and paid for in accordance with services included in the participant's service plan and verified by monthly visits conducted by the CCA.

ISCD runs billing queries for a random audit sample prior to onsite visits. Results may trigger follow up questions and requests for additional documentation to confirm billing practices. These audits are performed monthly, but they are limited to the amount of cases audited by staff during site visits. ISCD also runs quarterly queries to fulfill waiver reporting requirements, and uses obtained data to also review for inappropriate billing incidents. This process will trigger ad hoc onsite visits if/when billing discrepancies are identified.

ISCD works with the DHCS Audits and Investigation (A&I) team and DHCS' fiscal intermediary to recoup federal funds from the provider. ISCD monitors billing on a quarterly basis as well as focused queries prior to onsite visits in order to identify any potential billing issues. If issues are identified, ISCD will work with the Fiscal Intermediary and A&I for ad hoc reviews to further investigate any inappropriate billing and recoup payment if determined necessary. ISCD will coordinate with Accounting to process return of federal match claimed through inappropriate billings.
The steps to recoup funds will be as follows:

- *Determine at the RCFE/CCA facility to see if the beneficiary is still enrolled*
- *Notify DHCS supervisor of the potential billing issue*
- *DHCS supervisor will notify our Fiscal Intermediary and the Data Unit.*
- *Fiscal Intermediary will notify A&I to recoup funds.*
- *Correspondence will be mailed to the provider with the amount owed and the due date.*
- *Accounting notified of inappropriate billing and instructed to return federal match for any recoupments processed.*

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:

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:

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

○ ***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:

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:*

In the RCFE/ARF setting, the participant pays the facility directly for the provision of room and board at the beginning of the month from his/her SSI/SSP income, retaining the Personal Needs Allowance as governed by regulation. The facility bills the Medi-Cal program for the care rendered at the end of the month, only billing for the days in which the participant was enrolled in the waiver.

In the PSH setting, the participant pays their rent directly to the housing authority. The HHA is responsible for the preparation of food, but not the purchase of bulk food items

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	23915.64	5500.00	29415.64	46415.00	5600.00	52015.00	22599.36
2	25793.12	5665.00	31458.12	47807.00	5768.00	53575.00	22116.88
3	25659.47	5835.00	31494.47	49242.00	5941.00	55183.00	23688.53
4	25660.36	6010.00	31670.36	50719.00	6119.00	56838.00	25167.64
5	25650.68	6190.00	31840.68	52240.00	6303.00	58543.00	26702.32

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	7409	7409

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 2	7409		7409
Year 3	9660		9660
Year 4	13050		13050
Year 5	16440		16440

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) for waiver participants is 289 days. The ALOS is based on 372 reports from 17/18, 18/19, and 19/20.

ALW enrollment experience shows that participants enrolled in the waiver will maintain continuous enrollment until forced to leave due to illness or death. The ALOS is expected to remain constant each waiver year.

The ALOS estimate is consistent with the turnover rate. ALW enrollment trends show that the Waiver experiences an attrition rate of approximately 29% unduplicated participants on average each Waiver Year.

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:*

Enrollment levels per Tier were calculated by using an average of the three previous State fiscal years (2017/18, 2018/19, and 2019/20). Eligible participants for Tiers one through five are determined to be at the Nursing Facility Level A or Nursing Facility Level B Level of Care as per the California Code of Regulations (CCR) Sections 51120 (Intermediate Care Services, NF-A) and 51124 (Skilled Nursing Services NF-B).

Tier 1 11%
Tier 2 35%
Tier 3 18%
Tier 4 36%
Tier 5 1%

Estimated Number of Users: The number of unduplicated participants for each waiver year of this amendment is estimated using a baseline of 7409 unduplicated participants and 5744 maximum clients served. The State is assuming an increase of 194 clients per month. The growth rate of ALW participants is based on projected increases in the provider network and waiver capacity and allows for extra capacity in order to avoid dis-enrollments and waiting lists at waiver agencies. The baseline 5744 client count in Waiver Year 3 is based on the currently approved maximum waiver capacity.

Avg. Units/User: The utilization percentages were developed by calculating the percent of participants that utilized each service in 2017, 2018, and 2019 based on CMS 372 reports data. The percent utilization was applied to the projected participants going forward for 2021-2024.

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

The NF Transition Services, Service Assessment/Plan of Care Development, and Residential Habilitation utilizations and user cost per units are calculated based on an average of the 17/18, 18/19, and 19/20, 372 reports.

Factor D is calculated based on an average of the 17/18, 18/19, and 19/20, 372 reports. The state plans to add an additional 7,000 waiver slots to the currently approved ALW. The state assumes a monthly enrollment rate of approximate 194 clients until state FY 2023-2024.

Factor D utilization and cost are calculated based on an average of the 17/18, 18/19, and 19/20, 372 reports for NF Transition Services, Service Assessment/Plan of Care Development, and Residential Habilitation.

It is anticipated that NF Transition Services will be rendered to approximately 7% of new enrollees, with an estimated cost of 1,111.03 per unit. These numbers, and Assisted Living services average cost per unit, were derived from the average of 372 reports from FYs 17/18, 18/19, and 19/20.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is State Plan services and calculated based on the WY 16/17 372 report. There is a three percent projected increase in these costs for each WY. Factor D' estimates are slightly less than Factor G' estimates because State Plan services (Factor D') are less utilized because the Waiver provides continuous care to a lower acuity population.

Medicare Part D drug costs are not included in the Factor D estimates.

The state has updated the Factor D' projections to add in a 3% increase for each WY. For Factor D' projections, the state is basing a 3% increase to align with the California Legislature approved 3% compound annual increase for institutional facilities.

Factor D' is the estimated annual average per capita Medicaid cost for all services (state plan and services required under EPSDT(when a waiver serves children)) that are furnished in addition to waiver services while the individual is in the waiver. This calculation includes institutional costs when a person leaves the waiver for the institution and returns to the waiver in the same waiver year.

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 estimates are based on the assumption that 20% of the waiver participants are at NF-A level of care and the other 80% are at NF-B level of care. The state sampled claims data from institution costs with similar levels of care based on the average length of stay from the 14/15, 15/16, and 16/17, 372 reports.

The state added a conservative 3% increase each year to account for annual inflation in healthcare costs. The state is basing a 3% increase to each WY to align with the average increase of the historical California State Published for NF A/B 2014-17 rates.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G' estimates the State Plan services utilization during inpatient NF A/B hospitalizations and are based on an average of actual utilizations for WY1: $5,563; WY2: $6,838; WY 3: $4,369. The state assumed a three percent rate increase for each WY. The state is basing a 3% increase to align with the California Legislature approved 3% compound annual increase for institutional facilities.

Medicare Part D drug costs are not included in the Factor G' estimates.

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	
Assisted Living Services - Homemaker; Home Health Aide; Personal Care	
Care Coordination	
Residential Habilitation	
Augmented Plan of Care Development and Follow-up	
NF Transition Care Coordination	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Assisted Living Services - Homemaker; Home Health Aide; Personal Care Total:						***151803964.17***
Assisted Living Services - Homemaker; Home Health Aide; Personal Care	*Day*	*7409*	*251.00*	*81.63*	***151803964.17***	
Care Coordination Total:						***21337920.00***
Care Coordination	*Month*	*7409*	*9.00*	*320.00*	***21337920.00***	
Residential Habilitation Total:						***2365908.75***
Residential Habilitation	*15 Minute*	*15*	*23367.00*	*6.75*	***2365908.75***	
Augmented Plan of Care Development and Follow-up Total:						***24000.00***
Augmented Plan of Care Development and Follow-up	*Month*	*15*	*5.00*	*320.00*	***24000.00***	
NF Transition Care Coordination Total:						***1659200.00***
NF Transition	*One-time*	*1037*	*1.00*	*1600.00*	***1659200.00***	
				GRAND TOTAL:		***177190992.92***
				Total Estimated Unduplicated Participants:		***7409***
				Factor D (Divide total by number of participants):		***23915.64***
				Average Length of Stay on the Waiver:		*260*

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Services - Homemaker; Home Health Aide; Personal Care Total:						**165714213.49**
Assisted Living Services - Homemaker; Home Health Aide; Personal Care	Day	7409	251.00	89.11	**165714213.49**	
Care Coordination Total:						**21337920.00**
Care Coordination	Month	7409	9.00	320.00	**21337920.00**	
Residential Habilitation Total:						**2365908.75**
Residential Habilitation	15 Minute	15	23367.00	6.75	**2365908.75**	
Augmented Plan of Care Development and Follow-up Total:						**24000.00**
Augmented Plan of Care Development and Follow-up	Month	15	5.00	320.00	**24000.00**	
NF Transition Care Coordination Total:						**1659200.00**
NF Transition	One-time	1037	1.00	1600.00	**1659200.00**	

GRAND TOTAL:	**191101242.24**
Total Estimated Unduplicated Participants:	**7409**
Factor D (Divide total by number of participants):	**25793.12**
Average Length of Stay on the Waiver:	260

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Services - Homemaker; Home						**203814039.92**

GRAND TOTAL:	**247870460.20**
Total Estimated Unduplicated Participants:	**9660**
Factor D (Divide total by number of participants):	**25659.47**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Health Aide; Personal Care Total:						
Assisted Living Services - Homemaker; Home Health Aide; Personal Care	Day	9370	278.12	78.21	203814039.92	
Care Coordination Total:						28719091.20
Care Coordination	Month	9467	9.48	320.00	28719091.20	
Residential Habilitation Total:						14017335.48
Residential Habilitation	15 Minute	97	21862.12	6.61	14017335.48	
Augmented Plan of Care Development and Follow-up Total:						238393.60
Augmented Plan of Care Development and Follow-up	Month	386	1.93	320.00	238393.60	
NF Transition Care Coordination Total:						1081600.00
NF Transition	One-time	676	1.00	1600.00	1081600.00	

GRAND TOTAL:	247870460.20
Total Estimated Unduplicated Participants:	9660
Factor D (Divide total by number of participants):	25659.47
Average Length of Stay on the Waiver:	289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Services - Homemaker; Home Health Aide; Personal Care Total:						275355595.67

GRAND TOTAL:	334867721.60
Total Estimated Unduplicated Participants:	13050
Factor D (Divide total by number of participants):	25660.36
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Services - Homemaker; Home Health Aide; Personal Care	Day	12659	278.12	78.21	275355595.67	
Care Coordination Total:						38796710.40
Care Coordination	Month	12789	9.48	320.00	38796710.40	
Residential Habilitation Total:						18930628.33
Residential Habilitation	15 Minute	131	21862.12	6.61	18930628.33	
Augmented Plan of Care Development and Follow-up Total:						322387.20
Augmented Plan of Care Development and Follow-up	Month	522	1.93	320.00	322387.20	
NF Transition Care Coordination Total:						1462400.00
NF Transition	One-time	914	1.00	1600.00	1462400.00	

GRAND TOTAL:	334867721.60
Total Estimated Unduplicated Participants:	13050
Factor D (Divide total by number of participants):	25660.36
Average Length of Stay on the Waiver:	289

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Services - Homemaker; Home Health Aide; Personal Care Total:						346875399.64
Assisted Living Services - Homemaker;	Day	15947	278.12	78.21	346875399.64	

GRAND TOTAL:	421697122.61
Total Estimated Unduplicated Participants:	16440
Factor D (Divide total by number of participants):	25650.68
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Home Health Aide; Personal Care						
Care Coordination Total:						***48874329.60***
Care Coordination	*Month*	*16111*	*9.48*	*320.00*	***48874329.60***	
Residential Habilitation Total:						***23699412.56***
Residential Habilitation	*15 Minute*	*164*	*21862.12*	*6.61*	***23699412.56***	
Augmented Plan of Care Development and Follow-up Total:						***406380.80***
Augmented Plan of Care Development and Follow-up	*Month*	*658*	*1.93*	*320.00*	***406380.80***	
NF Transition Care Coordination Total:						***1841600.00***
NF Transition	*One-time*	*1151*	*1.00*	*1600.00*	***1841600.00***	

GRAND TOTAL:	***421697122.61***
Total Estimated Unduplicated Participants:	***16440***
Factor D (Divide total by number of participants):	***25650.68***
Average Length of Stay on the Waiver:	*289*