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 waiver's 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.

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 Self-Determination Program Waiver for Individuals with Developmental Disabilities

C. Type of Request: new

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**

[ ] **New to replace waiver**
Replacing Waiver Number:

[ ] **Migration Waiver** - this is an existing approved waiver
Provide the information about the original waiver being migrated
Base Waiver Number:
Amendment Number (if applicable):
Effective Date: *(mm/dd/yy)*

Waiver Number:CA.1166.R00.00
Draft ID: CA.001.00.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/18

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:

This waiver will serve individuals who, in the absence of this waiver, would require care in either an intermediate care facility for the developmentally disabled (ICF/DD), ICF/DD-H (habilitative) or ICF/DD-N (nursing.)

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.
California's Self Determination Program (SDP) Waiver for individuals with developmental disabilities offers home and community-based services not otherwise available through a participant's Medicaid program. The purpose of the SDP Waiver is to serve participants in their own homes and communities as an alternative to receiving services in an intermediate care facility for persons with developmental disabilities. The SDP Waiver allows participants the opportunity to accept greater control and responsibility regarding the delivery of needed services. With the receipt of appropriate supports and information, participants will be able to manage their service mix within an individual budget amount to achieve the goals and objectives of their individual program plans.

In California, community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, non-profit corporations known as regional centers. Regional centers, as established by the Lanterman Developmental Disabilities Service Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. The regional centers are community-based nonprofit corporations governed by volunteer Boards of Directors that include individuals with developmental disabilities, their families, a representative of the vendor community, and other defined community representatives.

Regional centers are funded through contracts with the State Department of Developmental Services (DDS). They are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. In addition, regional centers are responsible for developing, maintaining, monitoring and funding a wide range of services and supports to implement the plans of care [or individual program plans (IPP)] for consumers. The IPPs are developed using a person-centered planning approach.

DDS ensures, under the oversight of the Department of Health Care Services (DHCS), the State Medicaid Agency, that the SDP Waiver is implemented by regional centers in accordance with Medicaid law and the State's approved Waiver application.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
The State formed an advisory group consisting of service recipients, family members, service providers, regional center representatives and other community advocates to assist in the development of this waiver application. This advisory group and various subgroups met regularly over the course of the year prior to submitting the application to define the scope of the program, including the nature of the services included in this request. Additionally, information on the development and implementation of the Self-Determination Program was regularly posted to the DDS website. This group continues to meet in order to prepare for the implementation of the Self-Determination Program.

Public input was also sought by making the draft Waiver application available for comment. The application was posted on the Department of Developmental Services' (DDS) internet site on August 7, 2015, accompanied by an announcement published the same day in the California Regulatory Notice Register. The public comment period ran through September 7, 2015. During the comment period, seven individuals asked for and received copies of the draft application. Additionally, written comments were received from a total of seven individuals or organizations.

As a result of the public comments received, DDS changed the term "area boards" to the "State Council on Developmental Disabilities" throughout the application.

Below is a summary of other comments received and the reasons why they did not result in changes to the Waiver application.

• Comments regarding disenrollment rights are currently addressed in the application in Appendix E.

• Other comments expressed a need for training and information regarding:
o appropriate uses of individual budget funds,
o available services in self-determination,
o provider qualifications, and
o support to ensure individuals will have the opportunity to make informed choices before participating in the program
o delineation of roles and duties for Financial Management Services providers when acting as either a fiscal agent or co-employer
Training and information on these and other topics will be provided as part of the mandatory orientation referenced in Appendix E of the application. It is the intent that self-advocates/family members are an integral part of the orientation and training process. Additionally, DDS is currently engaged with stakeholders in developing comprehensive training materials.

• One comment suggested that having a limit on the size of licensed residential settings may be overly restrictive. This limit was included in consultation with the stakeholder advisory group. The State will discuss this topic with CMS during the review of the Waiver application.

• Some commenters suggested changes regarding payment responsibilities for criminal background checks, involvement of planning teams in setting individual budgets, and what services may be purchased with individual budget funds. The wavier application was not changed in response to these comments since they were in conflict to with the statute (California Welfare & Institutions Code section 4685.8) authorizing the Self-Determination Program.

• A comment was received regarding the need for Independent Facilitators to receive adequate training. The need and requirement for this training is contained in State statute.

• Comments were also received regarding the need for sufficient funding for the operation of the Self-Determination Program. This will be addressed as part of the State's legislative/budget development process.

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: Eberhardt-Rios

First Name: Sarah

Title: Chief, Integrated Systems of Care Division

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue, MS 4502

Address 2:

City: Sacramento

State: **California**

Zip: 95814

Phone: (916) 327-1902 **Ext:** ☐ **TTY**

Fax: (916) 552-9151

E-mail: Sarah.Eberhardt-Rios@dhcs.ca.gov

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

Last Name: Powell

First Name: Carie

Title: Chief, Federal Programs Operations Section

Agency: Department of Developmental Services

Address: 1600 Ninth Street, MS 3-9

Address 2:

City: Sacramento

State: **California**

Zip: 95814

Phone: (916) 654-2300 **Ext:** ☐ **TTY**

Fax: (916) 654-3256

E-mail: Carie.powell@dds.ca.gov

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: MARI CANTWELL

State Medicaid Director or Designee

Submission Date: Mar 13, 2018

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

Last Name: Kent

First Name: Jennifer

Title: Director

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue

Address 2:

City: Sacramento

State: California

Zip: 95814

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

Fax: (916) 440-7404

E-mail: Jennifer.kent@dhcs.ca.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

n/a

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

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

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

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

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

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

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:

   (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:
   Department of Developmental Services

   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:

The Department of Health Care Services (DHCS) is the California Medicaid Agency. DHCS has established an Interagency Agreement (IA) with the Department of Developmental Services (DDS), as the Organized Health Care Delivery System to administer the SDP Waiver for persons with developmental disabilities. The IA specifies the functions to be performed by both DHCS and DDS to ensure the administration of the waiver; the cost allocation plan; and the transfer of federal funds to DDS. The IA additionally specifies the oversight activities of DHCS, as well as billing and payment responsibilities of DHCS and DDS. The IA is reviewed and updated as needed.

DHCS exercises administrative oversight, on an ongoing and/or as-needed basis (unless otherwise specified), in the administration and supervision of the Waiver and reviews the performance of DDS in operating the Waiver as follows:

1. Reviews and approves Waiver manuals, program advisories, technical letters and any other policies, procedures, rules or regulations that DHCS may identify as specific to the Waiver.
2. Ensures the technical compliance and correctness of the IA between DHCS and DDS and any subsequent related contracts.
3. Prepares required annual Waiver reports, i.e., CMS 372.
4. Reviews, negotiates and approves amendment requests for the IA.
5. Develops documents and guidelines that are used for monitoring fiscal and programmatic elements of the IA.
6. Coordinates with DDS in the administration of the Waiver Monitoring Protocol. The Protocol specifies the performance monitoring, analysis and evaluation of the regional centers. The on-site monitoring reviews are conducted jointly by DHCS and DDS.
7. Monitors DDS follow-up to ensure that areas of non-compliance discovered during monitoring reviews of the regional centers are remediated.
8. Ensures follow-up reviews are conducted as necessary, to determine if the areas of non-compliance have been corrected. The scope of the follow-up review is based upon the nature and extent of the areas of non-compliance.
9. Retains the authority to conduct independent focused reviews (announced and unannounced) to investigate DDS follow-up on significant special incident reports. Selection criteria may include, but is not limited to, severity of the event, unusual nature of circumstances, participant/advocate complaints or Centers for Medicare & Medicaid Services (CMS) concerns/requests for investigation.
10. Retains the authority to initiate a full-scope monitoring review in addition to routine monitoring reviews when: (a) there is a failure of fiscal audit; (b) there is a lack of response to a corrective action plan; (c) in the course of a monitoring review, DHCS or DDS needs assistance from other departmental branches; or (d) DHCS elects to conduct a full scale review based on evidence of inadequate case management and or poor fiscal management by regional center.
11. Exercise oversight of Waiver operations by reviewing the performance data compiled through the Waiver Quality Management Systems (QMS). Through the Quality Management Executive Committee, DHCS collaborates with DDS in setting priorities for the Waiver quality improvement, in developing, implementing and monitoring remedial (system improvement) strategies; evaluating the effectiveness of interventions; and evaluating the effectiveness of the Waiver QMS.
12. DHCS exercises ongoing financial administration of the Waiver as follows:

a. Monitors DDS compliance with fiscal provisions specified in the IA regarding audits of regional center.
b. Reviews DDS audit protocol to ensure compliance with the Waiver and to ensure that DDS audits of regional centers are performed in accordance with established protocols and meet Generally Accepted Governmental Auditing Standards (GAGAS) requirements.
c. Review DDS regional center audit working papers on a sample basis and attends entrance and exit conference of selected regional center audits.
d. DHCS reviews DDS audits of regional centers. These audits are designed to “wrap around” the independent Certified Public Accountant (CPA) audit to ensure comprehensive financial accountability.
e. DHCS reviews DDS fiscal reviews of service providers and vendors as specified in the Waiver and the IA.
f. Refer and follow up on any program integrity issues that are identified as a result of oversight activities by

DHCS, DDS or other entities.
g. Issues an annual report to the DHCS Director and to CMS that summarizes oversight functions performed. A copy of the annual report is submitted to the DDS Director. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

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:

   Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, non-profit corporations known as regional centers. Regional centers, as established by the Lanterman Developmental Disabilities Services Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. The regional centers are community-based nonprofit corporations governed by volunteer Boards of Directors that include individuals with developmental disabilities, their families, a representative of the vender community, and other defined community representatives.

   Regional centers are funded through contracts with DDS. They are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. In addition, regional centers are responsible for developing, maintaining,

monitoring and funding a wide range of services and supports to implement the plans of care or IPP for consumers. The IPPs are developed using a person-centered planning approach.

Regional centers are responsible for ensuring that eligible consumers who want to participate on the Waiver are enrolled, financial management service providers meet the qualifications for providing Waiver services, IPPs are developed and monitored, consumer health and welfare is addressed and monitored, and financial accountability is assured.

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:
It is DDS' responsibility to ensure, with the oversight of DHCS, that the waiver is implemented by regional centers in accordance with Medicaid statute and regulation.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
DHCS and DDS perform operational oversight and monitoring of regional center Waiver operational performance through fiscal audits and program policy compliance. When taken together, the oversight and monitoring methods test all six assurances.

Audits and Financial Accountability:
• DDS performs fiscal audits of each regional center no less than every two years, and completes follow-up reviews of each regional center in alternate years. DDS will continue to require regional centers to contract with independent auditors to conduct an annual audit. The DDS audit is designed to "wrap around" the required independent CPA audit to ensure comprehensive financial accountability.
• DDS coordinates its activities with DHCS Audits and Investigations, who review DDS' audit reports of the regional centers on an ongoing basis.
Program Policy Compliance:
• The State's Biennial Waiver Monitoring reviews
o The review cycle is conducted every two years.
o The two-year review cycle consists of a statistically valid, statewide sample of Waiver participants selected at random. The size of the sample for each regional center varies depending on each regional center's percentage of the statewide total of Waiver participants.
o Consumers who had reportable special incidents during the review period are selected for a review of their records to assess the extent to which identified problems or issues were addressed in a timely and appropriate manner to continuously assure the health and safety of participants.
o DDS or DHCS may, at its own discretion, or in response to a complaint, do unannounced visits to a regional center or a provider.
Program Policy Follow-up Compliance Reviews:
• As needed, during the off-year cycle of the two-year reviews, follow-up monitoring and compliance reviews are conducted. This follow-up review focuses on the areas requiring implementation of a corrective action plan as identified by the previous compliance review, and progress in areas where changes were recommended. On-going training and technical assistance is provided as needed during the review process. The training and technical assistance covers, at a minimum, all aspects of the waiver program, and is designed to address the needs of administrators, case managers, and clinicians. Because the training and technical assistance is tailored to each individual region center's needs and is delivered on-site, it affords maximum opportunity to follow-up on issues identified in the compliance reviews.
Quality Assurance:
• DHCS and DDS jointly oversee the overall design and operation of a quality assurance program which allows it to continually plan, assess, assure, and improve the quality and effectiveness of services and the level of satisfaction of consumers. The system is outcome-based, focusing primarily on its customers, but also on its services and operations. The following are the key components of the State's quality assurance system:

o Through the planning team, development and periodic review (at least annually) of an individualized program plan for each consumer that addresses his or her health, living, and support needs.
o Quarterly monitoring visits by the regional centers for people living in licensed community care facilities or community out of home settings.
o Enhanced case management (at a minimum, face to face monitoring every 30 days for the first 90 days after transition to the community) for individuals moving from developmental centers to community living arrangements.
o Daily, DDS and regional center review and follow-up on special incidents.
o On an ongoing basis, review and investigation of health and safety complaints by protective services agencies, the State Council on Developmental Disabilities, Disability Rights California, DDS, regional centers, licensing agencies, and/or law enforcement agencies.
o Contracts with Disability Rights California to provide ongoing clients' rights advocacy services to individuals with developmental disabilities residing in the community.
o On an annual basis, DDS issues a report card to each center on Performance Contract outcomes. Each regional center is required to share these results with their community. DDS takes follow-up action as appropriate when decreases in the desired measures are noted.
o On an ongoing basis, DDS collects information about the fair hearing process including type(s) of services in dispute, the resolution of the appeals, and at what level (informal, mediation or state level) the appeal was resolved. DDS disseminates semi-annual reports to regional centers, and reviews the data for anomalies or irregularities with fair hearing filings, and monitors as needed.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of SDP Waiver policies and procedures reviewed by the Medicaid Agency found to be compliant. Numerator=number of SDP Waiver Monitoring Protocols, policies and procedures reviewed by the Medicaid Agency that are found to be compliant. Denominator=total number of SDP Waiver Monitoring Protocols, policies and procedures reviewed by the Medicaid Agency.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Periodic policy updates, monthly invoices, waiver applications/amendments.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of required coordination meetings conducted between the Medicaid Agency, DDS and DSS (As required). Numerator=number of coordination meetings conducted. Denominator=total number of planned coordination meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Coordination meetings conducted between the Medicaid Agency, DDS, and DSS

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:
	☑ **Other** Specify: At least semi-annually	

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 required oversight/monitoring meetings conducted between DDS and the Medicaid Agency. Numerator=number of oversight meetings conducted. Denominator=total number of planned oversight meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Oversight /monitoring meetings conducted between DDS and the Medicaid Agency

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: At least semi-annually	

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 DDS Quality Management Executive Committee (QMEC) Meetings conducted. Numerator=number of QMEC Meetings conducted. Denominator=total number of planned QMEC Meetings

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

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: At least semi-annually	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When individual problems are discovered, DDS, with oversight from DHCS, works with the regional centers to resolve the problem. For example, individual issues identified during the State's SDP Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Depending on the situation, resolution may require further site visits from

the regional center. The regional center's plans for correction submitted in response to the State's recommendations are evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center and forwarded to CMS. Individual problems identified through the other discovery methods identified above and elsewhere in this application are addressed in a similar fashion. Documentation of individual issues and resolution is maintained and aggregated by DDS and allows for system wide analysis by the Quality Management Executive Committee.

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: Regional Centers	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
		Brain Injury			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐				☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

California uses the State's definition of "developmentally disabled" and "substantial disability" for the target population of this waiver as defined in the California Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code 4512, as follows:
"Developmental disability" means a disability which originates before an individual attains age 18, continues or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include disabling conditions found to be closely related to mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation but shall not include other handicapping conditions that are solely physical in nature.
"Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity as determined by a regional center and as appropriate to the age of the person:
1. Self-care.
2. Receptive and expressive language.
3. Learning.
4. Mobility.
5. Self-Direction.
6. Capacity for independent living.
7. Economic self-sufficiency.
This waiver is limited to individuals want to direct all of their services.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

  [ ]

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

  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

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

      Specify the formula:

      [ ]

    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1000
Year 2	2500

Waiver Year	Unduplicated Number of Participants
Year 3	2500

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	

Appendix B: Participant Access and Eligibility

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

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

- ( ) **Not applicable. The state does not reserve capacity.**
- (●) **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
For current self determination pilot participants	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

For current self determination pilot participants

Purpose *(describe):*

Currently, approximately 150 individuals are participating in a State funded self-determination pilot project. Capacity is reserved in this Waiver to allow for the transition of all individuals currently participating in the pilot-project

Describe how the amount of reserved capacity was determined:

The reserve capacity is determined based on the current participants in the pilot project.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	150
Year 2	
Year 3	

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:

To ensure the program will be available on an equitable basis to participants in all regional center catchment areas, the number of Self-Determination Program participants in each regional center will be based on the relative percentage of total consumers served by the regional centers minus any remaining participants in the self-determination pilot projects previously authorized in 1998. If there is unused capacity in one or more regional center catchment areas, and it is determined there are no eligible participants who wish to enroll, unused capacity may be reallocated to the remaining regional centers based on the relative percentage of total consumers served by each regional center.

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

The Department of Developmental Services (DDS) will use a stratified random selection process for selecting entrants so that all interested individuals will have an equal opportunity to participate. The process will be as follows: First, DDS will receive lists of interested individuals who have participated in a required Informational Meeting. From these lists, DDS will randomly select participants for each regional center so selection will be representative of the State for ethnicity, age, gender, and disability diagnosis.

Informational Meetings will be publicized on websites by the entities conducting them (e.g. regional centers, the State Council on Developmental Disabilities, and its regional offices, community based organizations, etc.) Regional centers and Local Volunteer Advisory Committees will also publicize these meetings to help inform consumers and families when they occur.
SDP orientations will be scheduled and facilitated by regional center teams who will ensure each selected participant receives an orientation prior to enrollment. Orientations will occur as needed based on the availability of waiver slots.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  All other mandatory and optional groups covered under the plan are included.

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

The maximum amount of income to be eligible under the SDP Waiver including any income disregards or exemptions.

○ **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:

  The maximum amount of income to be eligible under the SDP Waiver, including any income disregards or exemptions.
- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Regional Centers

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:

Qualified Intellectual Disability Professional as defined in 42 CFR 483.430(a) Facility staffing.

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 Level Of Care (LOC) criteria are based on California Code of Regulations (CCR) Title 22, Sections 51343, 51343.1, 51343.2 which specify the LOC requirements for admittance to an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-H (Habilitative) or ICF/DD-N (Nursing). The Client Development Evaluation Report (CDER) is utilized in making LOC determinations.
These regulations indicate that an individual must have at least two moderate or severe support needs (qualifying conditions) in one or a combination of the following areas: self-help (e.g. dressing, personal care, etc.); social-emotional (e.g. aggression, running away, etc.); or health (e.g. tracheostomy care, apnea monitoring, etc.).

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

When assessing level of care (LOC), the regional center QIDP reviews the CDER data including the diagnostic, special conditions and personal outcomes sections. In addition to the CDER data, the QIDP reviews other pertinent information in the consumer's record, such as the Individual Program Plan, progress reports, medical and psychological evaluations and case management notes, to determine the Waiver qualifying conditions that significantly affect the consumer's ability to perform activities of daily living and or participate in community activities. The consumer must have a minimum of two qualifying conditions to meet the LOC requirements for this waiver.

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):*

Monthly State computer-generated reports of consumers who are due for re-evaluation are provided to regional centers one month in advance of the annual re-evaluation date. Each month, the State sends a report to all regional centers which includes all consumers requiring LOC re-evaluation the following month. Additionally, timeliness of regional center electronic reporting of annual reevaluations is monitored through use of the Medicaid Waiver Control Listing for Clients with Past Due Recertification report. Timeliness of the completion of re-evaluations is also monitored during the Waiver Monitoring Reviews.

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:

Records are kept at each of the 21 regional centers in each participant's file.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of applicants* who had a LOC determination. Numerator =number of consumer records that documented an initial LOC determination. Denominator=Total number of applicants whose records were reviewed. *an "applicant" is an individual who has been selected to potentially fill an open SDP slot.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☐ **Continuously and Ongoing**	Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The 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:
Number and percent of Level Of Care (LOC) determinations that were done utilizing the process outlined in the approved waiver. Numerator= number of consumer records reviewed that documented LOC determinations utilizing the process outlined in the approved waiver. Denominator= total number of consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each	

	regional center (RC) every two years.	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of LOC determinations that were completed accurately (e.g. supported by and consistent with other information in the consumer's records). Numerator=number of consumer records reviewed that documented accurate LOC determinations. Denominator=total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = 5
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Individual Level of Care (LOC) issues (e.g. appropriateness, timeliness, etc.) identified during the SDP Waiver Monitoring Reviews will be documented in monitoring reports which will be sent to the regional centers with the State's recommendations for resolution. The regional centers plans for correction submitted in response to the State's recommendations will be evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center.

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):*

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When an individual is determined to be likely to require a Level of Care determination described in Appendix B-6 of this request, the individual, or where appropriate his/her legal representative, will be informed of any feasible alternatives under the waiver and given the choice of waiver or institutional services prior to enrollment.
The regional center case manager ensures that:
1. Individuals, their legal representative, parents, relatives, or involved persons are given the choice of participating in the SDP waiver in lieu of institutional services, if the consumer is determined to be eligible for waiver services.

2. The individual's choice is documented on the Medicaid Waiver Consumer Choice of Services/Living Arrangement form DS 2200 at the time of any of the following:
• Determination of initial eligibility for the waiver.
• Reactivation of the waiver eligibility after an individual's termination from participation in the waiver.
• Transition from minor to adult status.
3. The consumer's choice to participate in the waiver is documented in a dated and signed DS 2200 form.

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

The signed Medicaid Waiver Consumer Choice of Services/Living Arrangement form, DS 2200, is retained in the participant's record at the regional center.

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):
During the development and/or review of the Individual Program Plan, consumers are informed of services under the SDP Waiver. Every effort is made to communicate in the preferred language of the consumer or family. These efforts include using a facilitator who may also be a member of the planning team, employing bilingual staff at the regional center, and/or using an interpreter or translator. WIC §4502.1 requires that information be provided in an understandable form to aid the consumer in making choices by all public or private agencies receiving state funds for the purpose of providing services to persons with developmental disabilities.

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	Community Living Supports
Statutory Service	Employment Supports
Statutory Service	Homemaker
Statutory Service	Live-In Caregiver
Statutory Service	Prevocational Supports
Statutory Service	Respite Services
Extended State Plan Service	Acupuncture Services
Extended State Plan Service	Chiropractic Service
Extended State Plan Service	Dental Services
Extended State Plan Service	Home Health Aide
Extended State Plan Service	Lenses and Frames
Extended State Plan Service	Occupational Therapy
Extended State Plan Service	Optometric/Optician Services
Extended State Plan Service	Physical Therapy
Extended State Plan Service	Psychology Services
Extended State Plan Service	Speech, Hearing and Language Services
Supports for Participant Direction	Financial Management Service
Supports for Participant Direction	Independent Facilitator
Other Service	Behavioral Intervention Services
Other Service	Communication Support
Other Service	Community Integration Supports
Other Service	Crisis Intervention and Support
Other Service	Environmental Accessibility Adaptations
Other Service	Family Support Services
Other Service	Family/Consumer Training

Service Type	Service
Other Service	Housing Access Supports
Other Service	Individual Training and Education
Other Service	Massage Therapy
Other Service	Non-Medical Transportation
Other Service	Nutritional Consultation
Other Service	Participant-Directed Goods and Services
Other Service	Personal Emergency Response Systems (PERS)
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment and Supplies
Other Service	Technology
Other Service	Training and Counseling Services for Unpaid Caregivers
Other Service	Transition/Set Up Expenses: Other Service
Other Service	Vehicle Modifications and Adaptations

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):

Community Living Supports

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Community Living Supports are services that facilitate independence and promote community integration for participants, regardless of the community living arrangement. Services include support and assistance with socialization, personal skill development, community participation, recreation and leisure, and home and personal care, among others, as further described below. Payments for Community Living Supports do not include the cost for room and board.

Community Living Supports are provided to a participant in his/her home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the participant to reside in the community and to participate as independently as possible. Services are provided in environments that support participant comfort, independence, preferences and the use of technology. The participant's choices are incorporated into the services and supports received. The participant has unrestricted access, and the participant's essential personal rights of privacy, dignity and respect, and freedom from coercion are protected.

The service settings are integrated in, and facilitate each participant's full access to the greater community, which includes opportunities for each participant to engage in community life, control personal resources, and receive services in the community.

The specific services provided to each participant will vary based on the individual, the individual's preferences and the community setting chosen. The specific types and mix of supports that an individual receives as well as any special provider qualifications shall be specified in the Individual Program Plan.

The following items describe the types of possible Community Living Supports:

1. Support with socialization includes development or maintenance of self-awareness and self-control, social responsiveness, social amenities, interpersonal skills, and personal relationships.

2. Support with personal skill development includes activities designed to improve the participant's own ability to accomplish activities of daily living, including eating, bathing, dressing, personal hygiene, mobility, and other essential activities.

3. Support with community participation includes assistance that enables the individual to more fully participate in community activities. Assistance may include, but is not limited to, the acquisition, use, and care of canine or other animal companions specifically trained to provide personal assistance, or devices to facilitate immediate assistance when threats to health, safety, or well-being occur.

4. Support to facilitate participation in post-secondary education, religious, recreation or leisure activities.

5. Support with home and personal care includes services needed to maintain the home in a clean, sanitary and safe environment and provide essential care to the individual. Services include support with household activities, such as planning and preparing meals, money management (personal finances, planning, budgeting and decision making), and laundry. It also includes heavy household chores such as washing floors, windows and walls, securing loose rugs and tiles, moving heavy items or furniture in order to provide safe access and egress, as well as minor repairs such as those which could be completed by a handyman. Heavy household chores and services that can be provided by a handyman are only available when the individual or anyone else in the household is unable to do the service. Services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. There will be no duplicate billing of homemaker or other similar personal care/assistance service.

6. Support includes the provision of medical and health care services that are integral to meeting the daily needs of the participant (e.g., routine administration of medications or tending to the needs of a participant who is ill or requires attention to medical needs on an ongoing basis.). Medical and health care services such as physician services that are not routinely provided to meet the daily needs of the participant are not provided.

7. Support and training for infant and childcare for participants who are, or will become parents.

Settings where Community Living Supports are provided must have all of the following qualities:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. The setting is selected by the individual from among setting options including non-disability specific settings

and an option for a private unit in a residential setting
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
5. Facilitates individual choice regarding services and supports, and who provides them.

In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:

• The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

1. Each individual has privacy in their sleeping or living unit:

• Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
• Individuals sharing units have a choice of roommates in that setting.
• Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

2. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

3. Individuals are able to have visitors of their choosing at any time.

4. The setting is physically accessible to the individual.

5. The unit or dwelling may be shared by no more than four waiver participants.

6. Any modification of the additional conditions specified in items 1 through 4 above, must be supported by a specific assessed need and justified in the individual program plan (IPP). The following requirements must be documented in the (IPP):

• Identify a specific and individualized assessed need.
• Document the positive interventions and supports used prior to any modifications to the IPP.
• Document less intrusive methods of meeting the need that have been tried but did not work.
• Include a clear description of the condition that is directly proportionate to the specific assessed need.
• Include regular collection and review of data to measure the ongoing effectiveness of the modification.
• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
• Include the informed consent of the individual.
• Include an assurance that interventions and supports will cause no harm to the individual.
Additionally, provider owned or leased facilities where these services are furnished must be compliant with the Americans with Disabilities Act.

The method by which the costs of room and board are excluded from the payment for this service is specified in Appendix I-5.

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

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

- [x] **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	Adult Residential Facility for Persons with Special Health Care Needs
Agency	Foster Family Agency (FFA)-Certified Family Homes
Agency	Small Family Homes
Agency	Residential Care Facility for the Elderly (RCFE)
Agency	Adult Residential Facility
Agency	Group Homes
Agency	Foster Family Homes
Agency	Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)
Agency	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Adult Residential Facility for Persons with Special Health Care Needs
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1567.87
Certificate *(specify):*
Other Standard *(specify):*
Welfare and Institutions Code §4684.50 seq
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social Services

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:
Foster Family Agency (FFA)-Certified Family Homes
Provider Qualifications
License *(specify):*
FFA licensed pursuant to Health and Safety Code §§1500-1567.8
Certificate *(specify):*
Title 22, CCR, § 88030
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Small Family Homes
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1567.8
Certificate *(specify):*
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social Services

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:
Residential Care Facility for the Elderly (RCFE)
Provider Qualifications
License *(specify):*
Health and Safety Code §§1569-1569.889
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social Services

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Adult Residential Facility
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1567.8
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social Services

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Group Homes
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1567.8
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social Services

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Foster Family Homes
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1567.8
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
AFH Title 17, CCR, §56088
Other Standard *(specify):*
FHA employs sufficient staff with the combined experience, training and education to perform the following duties:
1. Administration of the FHA;
2. Recruitment of family homes;
3. Training of FHA staff and family homes;
4. Ensuring an appropriate match between the needs and preferences of the consumer and the family home;
5. Monitoring of family homes;
6. Provision of services and supports to consumers and family homes which are consistent with the consumer's preferences and needs and the consumer's IPP; and
7. Coordination with the regional center and others.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional Centers, DDS, FHA

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.
Annually; Biennially; Monthly

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Supports

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals at least 18 years of age who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Individuals must have a demonstrated experience successfully providing this or similar services or demonstrated life experiences and skills to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

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:
Supported Employment

Alternate Service Title (if any):
Employment Supports

HCBS Taxonomy:

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

Service Definition *(Scope):*
This service is provided to participants tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to prepare and support the participant for community participation, interdependence, independence, and/or community integrated work.
This service supports the full access of participants receiving services in the community to seek employment and work in competitive integrated settings.
The participant selects this service from among service options including non-disability specific settings. The service options are based on the participant's individualized needs and preferences.
The participant receives this service in settings that are integrated in and support full access to the greater community, and allows for participant comfort, interdependence, independence, preferences, and use of any technology. The participant's choices are incorporated into the services and supports and his/her essential personal rights of privacy, dignity and respect and freedom from coercion are protected. The service settings must allow the participant to control personal resources. In addition, the settings must allow the participant to receive breaks in the same manner as a non-disabled individual.

Employment supports are individually designed and provided in the manner specified by the planning team to assist participants to gain and retain employment, including self-employment, in community integrated work environments to achieve the participant's personally defined outcomes. The intended outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal career goals. This service does not include payment for supervision training, support and adaptations typically available to other workers without disabilities working in similar positions in the business. These services and supports also include activities related to job discovery, self-employment, and retirement.

The participant may receive any combination of Employment Supports, including:

a. Physical capacities development, i.e., health concerns.
b. Psychomotor skills development.
c. Interpersonal, communicative/social and adaptive skills development, e.g., responding appropriately to supervisors/co-workers,
d. Work habits development, e.g., attendance and punctuality, focusing on tasks,.
e. Development of vocationally appropriate dress and grooming.
f. Productive skills development, i.e., the achievement of productivity standards and quality results.
g. Work-practices training, e.g., following directions, completing tasks,.
h. Work-related skills development, e.g., problem solving, path planning to future employment opportunities.
i. Money management and income reporting skills.
j. Development and use of natural job supports.
k. Workforce integration techniques.
l. Community integration development/relationship building.

m. Safety skills and training.
n. Job discovery, job-seeking, and interviewing skills.
o. Self-advocacy training, participant counseling, peer vocational counseling, career counseling, and peer club participation.
p. Volunteerism to assist the person in identifying job or career interests.
q. Individualized assessment.
r. Job analysis, job development and placement that produce an appropriate job match for the participant and employer.
s. Direct supervision or training while the participant is engaged in integrated work.
t. Job coaching provided on or off the worksite.
u. Counseling with a participant/family and/or authorized representative to ensure support of the participant in job adjustment or planning for retirement.
v. Counseling on benefits planning to ensure a consumer understands the relationship between earned income and receiving public benefits such as SSI, SSA, Medi-Cal, and PASS Plans.
w. Consultation with employer's Human Relations staff.
x. Assessment of need for technology and facilitating acquisition of communication aides and technology.
y. Job customization, e.g., modifications to work materials, procedures, and protocols.
z. Self-employment and business development, i.e., identification of potential business opportunities, business plan development, identification of needed supports, ongoing assistance and support.

Transportation from the participant's residence to their place of employment is not a component of this service. The above described services and supports cannot be provided when available under a program funded under §110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) or §602(16) and (17) of the Individuals with Disabilities Education Act (IDEA.)(20 U.S.C. 1401 (16 and 17)).

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications
License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals at least 18 years of age who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Entities must have demonstrated experience successfully providing this or similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possess the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals at least 18 years of age who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Individuals must have demonstrated experience successfully providing this or similar services or demonstrated life experiences and skills to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possess the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

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):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Services consisting of general household activities (meal preparation and routine household care) provided by an individual that has the requisite skills to perform homemaker duties specified in the participant's IPP when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):

Live-In Caregiver

HCBS Taxonomy:

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

Service Definition *(Scope):*

Live-in caregiver service provides for the payment 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 participant. This payment is available only in the case of participants who receive personal care support and live in homes that they rent, lease, or own. A legal guardian may not furnish this service. The way the amount that is paid is determined as specified in Appendix I-6. Payment is not made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

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

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

- [x] **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

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Live-In Caregiver

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:
Prevocational Services
Alternate Service Title (if any):
Prevocational Supports

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
This service is provided to participants tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to support and prepare the participant for community participation, interdependence, independence, and/or community integrated work.

The participant selects this service from among service options including non-disability specific settings. The service options are based on the participant's individualized needs and preferences.
The participant receives this service in settings that are integrated in and support full access to the greater community, and allows for participant comfort, interdependence, independence, preferences, and use of any technology. The participant's choices are incorporated into the services and supports and his/her essential personal rights of privacy, dignity and respect and freedom from coercion are protected. The service settings must allow the participant to control personal resources. In addition, the settings must allow the participant to receive breaks in the same manner as a non-disabled individual.

Prevocational supports are individually designed and provided in the manner specified by the planning team to assist participants to gain employment, including self-employment or volunteer work, in community integrated environments to achieve the participant's personally defined outcomes. These services and supports also include activities related to job discovery, self-employment, and retirement. The intended outcome of this service is to further habilitation goals that will lead to greater opportunities for competitive integrated employment and career advancement at or above minimum wage.

The participant may receive any combination of Prevocational Supports, including:

• Physical capacities development, i.e., health concerns.
• Psychomotor skills development.
• Interpersonal, communicative/social and adaptive skills development, e.g., responding appropriately to supervisors/co-workers.
• Work habits development, e.g., attendance and punctuality, focusing on tasks.
• Development of vocationally appropriate dress and grooming.
• Productive skills development, i.e., the achievement of productivity standards and quality results.
• Work-practices training, e.g., following directions, completing tasks.
• Work-related skills development, e.g., problem solving, path planning to future employment opportunities.
• Money management and income reporting skills.
• Volunteerism to assist the person in identifying job or career interests.

Prevocational supports are designed to prepare individuals in non-job-task-specific strengths and skills that contribute towards obtaining a competitive and integrated employment, as opposed to vocational services whose sole purpose is to provide employment without habilitation goals geared towards skill building.

Transportation from the participant's residence is not a component of this service. The above described services and supports cannot be provided when available under a program funded under §110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) or §602(16) and (17) of the Individuals with Disabilities Education Act (IDEA.)(20 U.S.C. 1401 (16 and 17)).
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	Business Entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Supports

Provider Category:
Agency
Provider Type:
Business Entity
Provider Qualifications
License *(specify):*
Providers must possess any valid license or certification required by State or local law
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable
Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals at least 18 years of age who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Entities must have demonstrated experience successfully providing this or similar services.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possess the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Supports

Provider Category:
Individual
Provider Type:
Individual

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals at least 18 years of age who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Individuals must have demonstrated experience successfully providing this or similar services or demonstrated life experiences and skills to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possess the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Respite Services are provided to participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature, with the exception of colostomy, ileostomy, catheter maintenance, and gastrostomy.

Respite can be any of the following:
1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Respite services may be purchased from qualified agencies or individuals. The participant may employ individual respite workers. In all cases, the IPP must specify the necessary training and skills that such workers or other providers must possess.

Respite Services may be provided in the following locations:
• Private residence.
• Residential facility approved by the State.
• Other community settings that are not a private residence, such as:
• Adult Family Home/Family Teaching Home
• Certified Family Homes for Children
• Adult Day Care Facility
• Camp
• Licensed Preschool
FFP will not be claimed for respite services provided beyond 30 consecutive days in a facility
Respite Services cannot be provided by the primary care provider or his/her spouse under this definition. Respite providers are required to develop and implement a back-up plan for times when they are scheduled, but are unable to come and provide the services.

Respite Services do not duplicate services provided under the Individuals with Disabilities Education Act (IDEA) of 2004. These services may only be provided when the care and supervision needs of a consumer exceed that of a person of the same age without developmental disabilities and will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Facility; Residential Facility: Residential Care Facility for the Elderly (RCFE)

Provider Category	Provider Type Title
Agency	Camping Services
Individual	Individual
Agency	Adult Day Care Facility
Agency	Child Day Care Facility; Child Day Care Center; Family Child Care Home
Agency	Respite Facility; Residential Facility: Small Family Homes (Children Only)
Agency	Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
Agency	Respite Agency
Agency	Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
Agency	Respite Facility; Residential Facility: Group Homes (Children Only)
Agency	Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home (AFH)/Family Teaching Home(FTH)
Agency	Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
Agency	Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency

Provider Type:
Respite Facility; Residential Facility: Residential Care Facility for the Elderly (RCFE)

Provider Qualifications

License *(specify):*
Health and Safety Code §§1569-1569.889 provides statutory authority for licensing of RCFEs. Identified as the CA Residential Care Facilities for the Elderly Act.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Title 22, CCR, §§87100-87793: Establish licensing requirements for facilities where 75 percent of the residents are sixty years of age or older. Younger residents must have needs compatible with other residents.
Administrator Qualifications:
1. Knowledge of the requirements for providing care and supervision appropriate to the residents.
2. Knowledge of and ability to conform to the applicable laws, rules and regulations.
3. Ability to maintain or supervise the maintenance of financial and other records.
4. Ability to direct the work of others.
5. Good character and a continuing reputation of personal integrity.
6. High school diploma or equivalent.
7. At least 21 years of age.
8. Criminal Record Clearance.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Camping Services

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

The camp submits to the local health officer either 1) Verification that the camp is accredited by the American Camp Association or 2) A description of operating procedures that addresses areas including supervisor qualifications and staff skill verification criteria.

Other Standard *(specify):*

Camp Director Qualifications: must be at least 25 years of age, and have at least two seasons of administrative or supervisory experience in camp activities.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross; and has the skill, training, or education necessary to perform the required services.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency
Provider Type:
Adult Day Care Facility
Provider Qualifications
License *(specify):*
Health and Safety Code §§ 1500 -1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency
Provider Type:
Child Day Care Facility; Child Day Care Center; Family Child Care Home
Provider Qualifications
License *(specify):*
Health and Safety Code §§ 1596.90 – 1597.621

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Child Day Care Center: Title 22 CCR, §§101151-101239.2

Family Child Care Home: Title 22 CCR §§102351.1-102424
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Small Family Homes (Children Only)

Provider Qualifications

License *(specify):*

Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Title 22, CCR §§ 83000-83088.
Regulations adopted by DSS to specify requirements for licensure of Small Family Homes.
Licensee/Administrator Qualifications
-Criminal Records/Child Abuse Index Clearance;
-At least 18 years of age;
-Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours is not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted:
o Child Development;
o Recognizing and/or dealing with learning disabilities;
o Infant care and stimulation;
o Parenting skills;
o Complexities, demands and special needs of children in placement;
o Building self esteem, for the licensee or the children;
o First aid and/or CPR;
o Bonding and/or safeguarding of children's property;
o Ability to keep financial and other records;
o Ability to recruit, employ, train, direct the work of and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency
Provider Type:
Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
Provider Qualifications
License *(specify):*
FFA licensed pursuant to Health and Safety Code §§1500-1567.8 provides statutory authority for DSS licensing of facilities identified in the CA Community Care Facilities Act.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes.
Other Standard *(specify):*
Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA's, certification and use of homes,
FFA administrator qualifications:
(1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or,
(2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position.
Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency
Provider Type:
Respite Agency
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*
The agency director shall possess at a minimum:
1. A bachelor's degree and a minimum of 18 months experience in the management of a human services delivery system, or;

2. Five years experience in a human services delivery system, including at least two years in a management or supervisory position.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Adult Residential Facilities (ARF)

Provider Qualifications

License *(specify):*

Health and Safety Code §§ 1500 through 1567.8

Certificate *(specify):*

Other Standard *(specify):*

Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception.
Administrator Qualifications
-At least 21 years of age;
-High school graduation or a GED;
-Complete a program approved by DSS that consists of 35 hours of classroom instruction
o 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities;
o 3 hrs. in business operations;
o 3 hrs. in management and supervision of staff;
o 5 hrs. in the psychosocial needs of the facility residents;
o 3 hrs. in the use of community and support services to meet the resident's needs;
o 4 hrs. in the physical needs of the facility residents;
o 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents;
o 4 hrs. on admission, retention, and assessment procedures;
-Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%.
-Criminal Record/Child Abuse Registry Clearance.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency
Provider Type:
Respite Facility; Residential Facility: Group Homes (Children Only)
Provider Qualifications
License *(specify):*
Health and Safety Code §§ 1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*
Title 22, CCR, § 84000-84808
Regulations adopted by DSS to specify requirements for licensure of Group Homes.
Administrator Qualifications:
1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children;
2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above);
3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or
4. Completed high school, or equivalent, plus at least three years administrative or supervisory experience (as above); and,
5. Criminal Records/Child Abuse Registry Clearance
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency
Provider Type:
Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home (AFH)/Family Teaching Home(FTH)
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
AFH Title 17, CCR, §56088
Authorizes the FHA to issue a Certificate of Approval to each family home which has:
1. Completed the criminal record review ;
2. Been visited by the FHA and a determination ensuring safe and reasonable and the prospective providers experience, knowledge, cooperation, history and interest to become an approved family home.
3. Completed required orientation and training.
Other Standard *(specify):*

Welfare and Institutions Code 4689.1-4689.6 provides statutory authority for FHA.
FHA employs sufficient staff with the combined experience, training and education to perform the following duties:
1. Administration of the FHA;
2. Recruitment of family homes;
3. Training of FHA staff and family homes;
4. Ensuring an appropriate match between the needs and preferences of the consumer and the family home;
5. Monitoring of family homes;
6. Provision of services and supports to consumers and family homes which are consistent with the consumer's preferences and needs and the consumer's IPP; and
7. Coordination with the regional center and others.
In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency

Provider Type:
Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs

Provider Qualifications

License *(specify):*
Health and Safety Code §§1500-1569.87

Appropriate license DSS CCLD as to type of facility

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Welfare and Institutions Code, § 4684.50 et seq.
The administrator must:
3. Complete the 35-houradministrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception,
4. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
e. A licensed registered nurse.
f. A licensed nursing home administrator.
g. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
h. An individual with a bachelors degree or more advanced degree in the health or human services

field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Agency

Provider Type:
Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Provider Qualifications

License *(specify):*
Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Acupuncture Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

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

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

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

Service Definition *(Scope):*
Acupuncture services are covered to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Acupuncture is defined in the Business and Professions Code, Section 4927 as "the stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping, and moxibustion." Acupuncture services (with or without electric stimulation of the needles) are limited to two services in any one calendar month, although additional services can be provided based upon medical necessity. All medically acupuncture services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Acupuncture services in this waiver are only provided to individuals age 21 and over and only when the limits of services furnished under the approved state plan are exhausted.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Acupuncturist
Agency	Licensed Acupuncturist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Acupuncture Services

Provider Category:
Individual
Provider Type:
Licensed Acupuncturist

Provider Qualifications

License *(specify):*
Business and Professions Code §§ 4935-4949

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Acupuncture Services

Provider Category:
Agency

Provider Type:
Licensed Acupuncturist

Provider Qualifications

License *(specify):*
Business and Professions Code §§ 4935-4949

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Chiropractic Service

HCBS Taxonomy:

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

Service Definition *(Scope):*

Chiropractic services include the manual manipulation of the spine to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. A chiropractor may use all necessary mechanical, hygienic, and sanitary measures incident to the care of the body, including, air, cold, diet, exercise, heat, light, massage, physical culture, rest, ultrasound, water, and physical therapy techniques in the course of chiropractic manipulations and/or adjustments. All medically necessary Chiropractic services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Chiropractic services in this waiver are only provided to individuals age 21 and over and only when the limits of services furnished under the approved state plan are exhausted..

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chiropractor
Individual	Chiropractor

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Chiropractic Service

Provider Category:
Agency
Provider Type:
Chiropractor
Provider Qualifications
License *(specify):*
Issued by the State Board of Chiropractic Examiners pursuant to the Business and Professions Code, §§ 1000-1058
Certificate *(specify):*
Other Standard *(specify):*
Doctor of Chiropractic (D.C.) degree from a Board-approved college
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Chiropractic Service

Provider Category:
Individual
Provider Type:
Chiropractor
Provider Qualifications
License *(specify):*
Issued by the State Board of Chiropractic Examiners pursuant to the Business and Professions Code, §§ 1000-1058
Certificate *(specify):*
Other Standard *(specify):*
Doctor of Chiropractic (D.C.) degree from a Board-approved college
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Dental Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Dental services are defined in Title 22, California Code of Regulations, Section 51059 as professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.

All medically necessary dental services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Dental services in this waiver are only provided to individuals age 21 and over and only when the limits of dental services furnished under the approved state plan are exhausted. Dental services in the approved state plan are limited to $1800 annually or by the amount that is determined medically necessary

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dentist

Provider Category	Provider Type Title
Individual	Dentist
Agency	Dental Hygienist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:
Agency
Provider Type:
Dentist
Provider Qualifications
License *(specify):*
Business & Professions Code §§ 1600-1976

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:
Individual
Provider Type:
Dentist
Provider Qualifications
License *(specify):*
Business & Professions Code §§ 1600-1976

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:
Agency

Provider Type:
Dental Hygienist

Provider Qualifications

License *(specify):*
Dental Hygienist: Licensed Dental Hygienist by the Dental Hygiene Committee of California pursuant to Business and Professions Code §§1900-1966.6

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Home Health Aide

HCBS Taxonomy:

Category 1:	Sub-Category 1:

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

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

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

Service Definition *(Scope):*
Home health aide services defined in 42 CFR §440.70 are provided to individuals age 21 and over and only when the limits of home health aide services furnished under the approved State plan limits are exhausted. Home health aide services under the state plan are limited to the amount that is determined medically necessary. All medically necessary home health aide services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Home Health Aide
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Home Health Aide

Provider Category:
Individual
Provider Type:
Home Health Aide
Provider Qualifications
License *(specify):*
Health and Safety Code §§1725 – 1742

Title 22, CCR, §74600 et. seq.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Home Health Aide

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*
Health and Safety Code §§1725 – 1742

Title 22, CCR, §74600 et. seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Lenses and Frames

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
This service covers prescription lenses and frames for consumers over 21 as prescribed by a physician and only when the limits of prescription lenses and frames furnished under the approved state plan are exhausted. All medically necessary Prescription Lens/Frames for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Prescription Lens/Frames under the state plan are limited to beneficiaries under 21 years old and residents of a nursing home. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. Prescription lenses and frames will not supplant services available through the approved Medicaid State plan or the EPSDT benefit

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dispensing Optician
Individual	Dispensing Optician

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Lenses and Frames

Provider Category:
Agency

Provider Type:

Dispensing Optician

Provider Qualifications

License *(specify):*

Business and Professions Code §§ 2550-2560

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Lenses and Frames

Provider Category:

Individual

Provider Type:

Dispensing Optician

Provider Qualifications

License *(specify):*

Business and Professions Code §§ 2550-2560

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Occupational Therapy services are defined in Title 22, California Code of Regulations, Sections 51085, and 51309 as services designed to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness or advanced age. Occupational therapy includes evaluation, treatment planning, treatment, instruction and consultative services. All medically necessary occupational therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Occupational therapy in this waiver is only provided to individuals age 21 and over and only when the limits of occupational therapy services furnished under the approved state plan are exhausted. Occupational therapy services in the approved state plan are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: audiology, acupuncture, chiropractic, psychology, podiatry, and speech therapy or the amount determined medically necessary.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Occupational Therapist
Individual	Occupational Therapist

Provider Category	Provider Type Title
Agency	Occupational Therapist Assistant

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Occupational Therapist
Provider Qualifications

License *(specify):*
Occupational Therapist: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications

License *(specify):*
Occupational Therapist: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:
Occupational Therapist Assistant

Provider Qualifications

License *(specify):*
Occupational Therapist Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Optometric/Optician Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Optometric/Optician Services are defined in Title 22, California Code of Regulations, Sections 51093 and 51090, respectively. Optometric services means any services an optometrist may perform under the laws of this state. Dispensing optician means an individual or firm which fills prescriptions of physicians for prescription lenses and kindred products and fits and adjusts such lenses and spectacle frames. A dispensing optician is also authorized to act on the advice, direction and responsibility of a physician or optometrist in connection with the fitting of a contact lens or contact lenses.

All medically necessary Optometric/Optician services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Optometric/Optician services in this waiver are only provided to individuals age 21 and over and only when the limits of Optometric/Optician services furnished under the approved state plan are exhausted. Optometric/Optician Services under the state plan are limited to one eye exam every 24 months, however, this limit can be exceeded based on medical necessity. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Orthoptic Technician
Agency	Optometrist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Optometric/Optician Services

Provider Category:
Agency
Provider Type:
Orthoptic Technician
Provider Qualifications
License *(specify):*
Business and Professions Codes in Chapter 7, Article 3

Sections 3041, 3041.3, 3056, 3057
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Optometric/Optician Services

Provider Category:
Agency
Provider Type:
Optometrist
Provider Qualifications
License *(specify):*
An optometrist is validly licensed as an optometrist by the California State Board of Optometry

As appropriate, a business license as required by the local jurisdiction where the business is located
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Physical Therapy services are defined in Title 22, California Code of Regulations, Sections 51081, and 51309 as services of any bodily condition by the use of physical, chemical, and or other properties of heat, light, water, electricity or sound, and by massage and active, resistive or passive exercise. Physical therapy includes evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications.

All medically necessary physical therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Physical therapy in this waiver is only provided to individuals age 21 and over and only when the limits of physical therapy services furnished under the approved state plan are exhausted. Physical therapy services in the approved state plan are limited to six month treatments and may be renewed if determined medically necessary.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Physical Therapist
Agency	Physical Therapy Assistant
Agency	Physical Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications

License *(specify):*
Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Physical Therapy Assistant
Provider Qualifications

License *(specify):*
Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency

Provider Type:
Physical Therapist

Provider Qualifications

License *(specify):*
Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:

Psychology Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Psychology Services are defined in Title 22, California Code of Regulations, Section 51099 as the services of a person trained in the assessment, treatment, prevention, and amelioration of emotional and mental health disorders.

All medically necessary psychology services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Psychology services in this waiver are only provided to individuals age 21 and over and only when the limits of psychology services furnished under the approved state plan are exhausted. The approved state plan limits this service to the amount that is medically necessary
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Clinical Psychologist
Individual	Clinical Psychologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Psychology Services

Provider Category:
Agency
Provider Type:
Clinical Psychologist
Provider Qualifications
License *(specify):*
Business and Professions Code, §§2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Psychology Services

Provider Category:
Individual
Provider Type:
Clinical Psychologist
Provider Qualifications
License *(specify):*
Business and Professions Code, §§2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech, Hearing and Language Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Speech, Hearing and Language services are defined in Title 22, California Code of Regulations, Sections 51096, 51098, and 51094.1 as speech pathology audiology services, and hearing aids, respectively. Speech pathology services mean services for the purpose of identification, measurement and correction or modification of speech, voice or language disorders and conditions, and counseling related to such disorders and conditions. Audiological services means services for the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and the recommendation and evaluation of hearing aids. Hearing aid means any aid prescribed for the purpose of aiding or compensating for impaired human hearing loss.

All medically necessary speech, hearing and language services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Speech, hearing and language services in this waiver are only provided to individuals age 21 and over and only when the limits of speech, hearing and language services furnished under the approved state plan are exhausted. Speech, hearing and language services in the approved state plan are limited to two services in any one calendar month or any combination of two services per month; Hearing aid benefits are subject to a $1,510 maximum cap per beneficiary per fiscal year or the amount determined medically necessary.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Audiologist
Individual	Speech Pathologist
Agency	Audiologist
Agency	Speech Pathologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Individual
Provider Type:
Audiologist
Provider Qualifications

License *(specify):*
Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Individual
Provider Type:
Speech Pathologist
Provider Qualifications

License *(specify):*
Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Agency

Provider Type:
Audiologist

Provider Qualifications

License *(specify):*
Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Agency

Provider Type:
Speech Pathologist

Provider Qualifications

License *(specify):*

Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:
Financial Management Services

Alternate Service Title (if any):
Financial Management Service

HCBS Taxonomy:

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

Service Definition *(Scope):*
This service assists the family or participant to: (a) manage and direct the disbursement of funds contained in the participant's individual budget, and ensure that the participant has the financial resources to implement his or her Individual Program Plan (IPP) throughout the year; (b) facilitate the employment of service providers by

the family or participant, as either the participant's fiscal agent or co-employer, by performing such employer responsibilities including, but not limited to, processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the participant or family and others as required.

This service includes the following activities to assist the participant in their role as either the employer or co-employer:
1. Assisting the participant in verifying worker's eligibility for employment and provider qualifications
2. Ensuring service providers employed by the participant meet criminal background checks as required and as requested by the participant.
3. Collecting and processing timesheets of workers.
4. Processing payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
5. Tracking, preparing and distributing reports (e.g., expenditure) to appropriate individual(s)/entities.
6. Maintaining all source documentation related to the authorized service(s) and expenditures.
7. Maintaining a separate accounting for each participant's participant-directed funds.
8. Providing the participant and the regional center service coordinator with a monthly individual budget statement that describes the amount of funds allocated by budget category, the amount spent in the previous 30-day period, and the amount of funding that remains available under the participant's individual budget.
9. Ensuring payments do not exceed the amounts outlined in the participant's individual budget
10. Fulfilling other FMS responsibilities as mandated by local, state and federal laws and regulations.

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

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

- [x] **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	Financial Management Service
Individual	Financial Management Service

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Service

Provider Category:
Agency
Provider Type:
Financial Management Service
Provider Qualifications

License *(specify):*
Business license, based on the type of business the FMS is operating (e.g. California Corporation (for profit or non-profit), Limited Liability Company, General Partnership, Limited Liability Partnership.)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional center

Frequency of Verification:
Verified upon application and ongoing thereafter through oversight and monitoring activities

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Service

Provider Category:
Individual

Provider Type:
Financial Management Service

Provider Qualifications

License *(specify):*
Business license, based on the type of business the FMS is operating (e.g. California Corporation (for profit or non-profit), Limited Liability Company, General Partnership, Limited Liability Partnership.)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional center

Frequency of Verification:
Verified upon application and ongoing thereafter through oversight and monitoring activities

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:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:
Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Independent Facilitator

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Independent Facilitator means a person, selected and directed by the participant, who is not otherwise providing services to the participant pursuant to his or her IPP. The service or function is intended to assist the participant to plan for and access services to implement needed services identified in the participant's IPP. The services may include, but are not limited to:
1. Participate in the person-centered planning process.
2. Identify immediate and long-term needs, preferences, goals and objectives of the participant for developing the IPP.
3. Make informed decisions about the individual budget.
4. Develop options to meet the identified immediate and long-term needs and access community services and supports specified in the IPP.
5. Advocate on behalf of the participant in the person-centered planning process and development of the IPP, obtaining identified services and supports.

The participant/family may hire, or contract with an IF, and shall specify in the IPP the activities which the IF will conduct. A participant may elect to use his or her regional center service coordinator to fulfill the functions of an IF, instead of contracting with, or using the service of an independent facilitator. This service does not duplicate services provided by the participant's service coordinator.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Independent Facilitator

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
An independent facilitator must complete training in the principles of self-determination, the person-centered planning process and other responsibilities described in statute (W&IC Section 4685.8(c)(2).)

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Independent Facilitator

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
An independent facilitator must complete training in the principles of self-determination, the person-centered planning process and other responsibilities described in statute (W&IC Section 4685.8(c)

(2).)

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Behavioral Intervention Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Behavior intervention services include the use and development of intensive behavioral intervention programs to improve the participant's development and behavior tracking and analysis. The intervention programs are restricted to generally accepted, evidence-based, positive approaches. Depending on the participant's needs, behavioral intervention services may be provided in multiple settings, including the participant's home, workplace, etc. Behavioral intervention 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. Services may be provided to family members if they are for the benefit of the participant. Services for family members may include training and instruction about treatment regimens, including training on the use of medications, and risk management strategies to enable the family to support the participant.

The participation of parent(s) of minor children is critical to the success of a behavioral intervention plan. The person-centered planning team determines the extent of participation necessary to meet the individual's needs. "Participation" includes the following meanings: Completion of group instruction on the basics of behavior intervention; Implementation of intervention strategies, according to the intervention plan; If needed, collection of data on behavioral strategies and submission of that data to the provider for incorporation into progress reports; Participation in any needed clinical meetings; provision of suggested nominal behavior modification materials or community involvement if a reward system is used. If the absence of sufficient participation prevents successful implementation of the behavioral plan, other services will be provided to meet the individual's identified needs.

This service in the HCBS Waiver is only provided to individuals age 21 and over. All medically necessary Behavioral Intervention Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychiatrist
Individual	Licensed Psychiatric Technician
Individual	Behavior Management Consultant: Licensed Clinical Social Worker
Individual	Individual
Individual	Behavior Management Consultant: Marriage Family Child Counselor
Individual	Behavior Analyst
Individual	Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)
Agency	Behavior Management Consultant: Licensed Clinical Social Worker
Individual	Family Counselor (MFCC), Clinical Social Worker (CSW)
Individual	Behavior Management Consultant: (Psychologist)
Individual	Associate Behavior Analyst
Agency	Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)
Agency	Behavior Analyst
Agency	Psychiatrist
Agency	Licensed Psychiatric Technician
Agency	Family Counselor (MFCC), Clinical Social Worker (CSW)
Agency	Behavior Management Consultant: (Psychologist)
Agency	Associate Behavior Analyst
Agency	Behavior Management Consultant: Marriage Family Child Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Psychiatrist

Provider Qualifications

License *(specify):*
Business and Professions Code §2000

Licensed as a physician/ surgeon by the California Medical Board.

As appropriate a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Certified by the American Board of Psychiatry and Neurology

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Licensed Psychiatric Technician

Provider Qualifications

License *(specify):*
Business and Professions Code §4500 et. seq.

Possess a valid psychiatric technician license issued by the California State Board of Vocational Nurse and Psychiatric Technician examiners.

As appropriate a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Behavior Management Consultant: Licensed Clinical Social Worker
Provider Qualifications
License *(specify):*
Business and Professions Code, §4996-4996.2

As appropriate a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.s.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Verification of Provider Qualifications
Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Behavior Management Consultant: Marriage Family Child Counselor

Provider Qualifications

License *(specify):*

Business and Professions Code §§4980-4981

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the National Behavior Analyst Certification Board.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)

Provider Qualifications

License *(specify):*
Business and Professions Code §2913; §4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Registered as either:
1. A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or
2. An Associate Licensed Clinical Social Worker pursuant to Business and Professions Code, Section 4996.18.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency

Provider Type:
Behavior Management Consultant: Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*
Business and Professions Code, §4996-4996.2

As appropriate a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Family Counselor (MFCC), Clinical Social Worker (CSW)

Provider Qualifications

License *(specify):*
Valid license with the California Board of Behavioral Science Examiners

As appropriate, a business license as required by the local jurisdiction where the business is located.

MFCC: Business and Professions Code §§4980-4984.9

CSW: Business and Professions Code §§4996-4997

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:

Behavior Management Consultant: (Psychologist)

Provider Qualifications

License *(specify):*

Business and Professions Code, §2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Associate Behavior Analyst

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the National Behavior Analyst Certification Board

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)

Provider Qualifications

License *(specify):*

Business and Professions Code §2913; §4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Registered as either:
1. A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or
2. An Associate Licensed Clinical Social Worker pursuant to Business and Professions Code, Section 4996.18.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the National Behavior Analyst Certification Board.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Business and Professions Code §2000

Licensed as a physician/ surgeon by the California Medical Board.

As appropriate a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the American Board of Psychiatry and Neurology

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Licensed Psychiatric Technician

Provider Qualifications

License *(specify):*

Business and Professions Code §4500 et. seq.

Possess a valid psychiatric technician license issued by the California State Board of Vocational Nurse and Psychiatric Technician examiners.

As appropriate a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency
Provider Type:
Family Counselor (MFCC), Clinical Social Worker (CSW)
Provider Qualifications
License *(specify):*
Valid license with the California Board of Behavioral Science Examiners

As appropriate, a business license as required by the local jurisdiction where the business is located.

MFCC: Business and Professions Code §§4980-4984.9

CSW: Business and Professions Code §§4996-4997
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency
Provider Type:
Behavior Management Consultant: (Psychologist)
Provider Qualifications
License *(specify):*
Business and Professions Code, §2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Associate Behavior Analyst

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the National Behavior Analyst Certification Board

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Management Consultant: Marriage Family Child Counselor

Provider Qualifications

License *(specify):*

Business and Professions Code §§4980-4981

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Communication Support

HCBS Taxonomy:

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

Service Definition *(Scope):*
Communication support services includes communication aides necessary to facilitate and assist persons with hearing, speech, or vision impairment, including individuals who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English (Limited English Proficient or LEP skills). The purpose of this service is to assist individuals to effectively communicate with service providers, family, friends, co-workers, and the general public. The following are allowable communication aides, as specified in the participant's IPP:
1. Facilitators;
2. Interpreters and interpreter services;
3. Translators and translator services; and
4. Readers and reading services.
This service also includes supports for the participant to use computer technology to assist in communication. Such supports include training in the use of the technology, assessment of need for ongoing training and support, and identification of resources for the support. This service is limited to personnel providing assistance and does not include the purchase the purchase of equipment or supplies.
Communication support services include evaluation for, and training in the use of, communication aides, including for individuals with LEP skills, as specified in the participant’s IPP.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Support

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Support

Provider Category:

Individual

Provider Type:
Individual
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Community Integration Supports

HCBS Taxonomy:

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

Service Definition *(Scope):*

This service is provided to participants tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to prepare and support the participant for community participation, interdependence, and independence.
This service supports the full access of to engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving these services. In addition, this service assists the participant to learn the skills needed to participate in the community during integrated activities with individuals who are non-disabled.
The participant selects this service from among service options including non-disability specific settings. The service options are based on the participant's individualized needs and preferences.
The participant receives this service in settings that are integrated in and supports full access to the greater community, and allows for participant comfort, interdependence, independence, preferences, and use of any technology. The participant's choices are incorporated into the services and supports and his/her essential personal rights of privacy, dignity and respect and freedom from coercion are protected. The service settings must allow the participant to control personal resources and his/her schedule and activities. In addition, the settings must allow the participant to receive breaks in the same manner as a non-disabled individual.
Community Integration Supports are provided in the manner specified by the planning team to assist participants with acquisition, retention, or improvement in self-help, socialization and adaptive skills through therapeutic and/or physical activities to achieve the participant's personally defined outcomes. These services and supports may take place in a wide variety of community-based settings that promote community integration. These settings may include those non-residential settings identified in Appendix C-5, but only if the setting is determined to meet the HCB settings requirements, using the process described in Appendix C-5. Services may be provided on a regularly scheduled basis, for one or more days per week. These services are not provided in the participant's residence.
These services and supports enable the participant to attain or maintain his or her maximum functional level, interdependence, and independence, including the facilitation of connections to community events and activities. In addition, these services and supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, enabling the participant to integrate into the community.
Services and supports to assist the participant to increase and improve self-help, socialization, community integration, and adaptive skills, may include:
a. Socialization and community awareness.
b. Communication skills.
c. Visual, auditory and tactile awareness, and perception experiences.
d. Development of appropriate peer interactions and self-advocacy skills.
e. Art and recreation programs.
f. Continuing Education i.e., classes that help participants explore interests or improve academic skills or complete a high school equivalency (GED) diploma while in an inclusive setting
g. Senior and faith-based groups.
h. Peer mentoring.
i. Mobility services, i.e., the access and use of public transportation or other modes of transportation, including access to peer-to-peer ride sharing.
j. Friendship and relationship building

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Individual
Agency	Business entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Supports

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals at least 18 years of age who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Supports

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications
License *(specify):*
Providers must possess any valid license or certification required by State or local law

Facility license (Health and Safety Code §§ 1500-1567.8) if applicable
Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals at least 18 years of age who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and annually thereafter through the IPP process.

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:
Crisis Intervention and Support

HCBS Taxonomy:

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

Service Definition *(Scope):*
Crisis Intervention and Support is a specialized service that provides short-term care and behavior intervention to provide relief and support of the caregiver and protection for the participant or others living with the participant. This service may include the use and development of intensive behavioral intervention programs to improve the participant's development and behavior tracking and analysis. This service is restricted to generally accepted, evidence-based, positive approaches.

This service is designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. The service may be provided to family members if they are for the benefit of the participant. The service for family members may include training and instruction about treatment regimens, including training on the use of medications, and risk management strategies to enable the family to support the participant. The participation of parent(s) of minor children is critical to the success of a behavioral intervention program.

The person-centered planning team determines the extent of participation necessary to meet the participant's

needs. Crisis Intervention and Support includes mobile crisis intervention in the participant's home, and/or community or where crisis intervention services are needed. Mobile crisis intervention means immediate therapeutic intervention on a 24-hour emergency basis to a participant exhibiting acute personal, social, and/or behavioral problems. Mobile crisis intervention provides immediate and time-limited professional assistance to a participant who is experiencing personal, social or behavioral problems which, if not ameliorated, will escalate and require that the participant be moved to a setting where additional services are available.

As necessary, Crisis Intervention and Support is composed of the following participant-specific activities:
1. Assessment to determine the precipitating factors contributing to the crisis.
2. Development of an intervention plan in coordination with the planning team.
3. Consultation and staff training to the service provider as necessary to ensure successful implementation of the participant's specific intervention plan.
4. Collection of data on behavioral strategies and submission of that data to the caregiver or provider for incorporation into progress reports.
5. Participation in any needed clinical meetings.
6. Development and implementation of a transition plan to aid the participant in returning home if out-of-home crisis intervention was provided.
7. Ongoing technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the participant.
8. Provision of recommendations to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the participant in the community.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Business entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention and Support

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention and Support

Provider Category:
Agency

Provider Type:
Business entity

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Those physical adaptations to the participant's home, required by the individual's IPP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would be at risk for institutionalization. These services are allowed only when another entity (i.e. landlord) is not responsible for making the needed adaptation (s).
Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Provided that they are allowable, other environmental accessibility adaptations and repairs may be approved on a case-by-case basis as technology changes or as a participant's physical or environmental needs change. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.. All services shall be provided in accordance with applicable State or local building codes.
• It may be necessary to make environmental modifications to an individual's home before he/she transitions from an institution to the community. Such modifications may be made while the person is institutionalized. Environmental modifications, included in the individual's plan of care, may be furnished up to 180 days prior to the individual's discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Business entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency

Provider Type:
Business entity

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Support Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home. This service is provided in the recipient's own home or in an approved out of home location to do all of the following:

1. Assist family members in maintaining the recipient at home;
2. Provide appropriate care and supervision to protect the recipient's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a recipient; and
4. Attend to the recipient's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by family members.

Payment for family support services may only be made when the cost of the service exceeds the cost of providing services to a person of the same age without disabilities.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Child Day Care Facility; Child Day Care Center; Family Child Care Home
Agency	Child Day Care Facility; Child Day Care Center; Family Child Care Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support Services

Provider Category:

Individual

Provider Type:

Child Day Care Facility; Child Day Care Center; Family Child Care Home

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support Services

Provider Category:

Agency

Provider Type:

Child Day Care Facility; Child Day Care Center; Family Child Care Home

Provider Qualifications

License *(specify):*

Licensed Child Day Care Facility by the Department of Social Services pursuant to Health and Safety Code
§§ 1596.90 – 1597.621
As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

Child Day Care Center: Title 22 CCR, §§101151-101239.2
Family Child Care Home: Title 22 CCR §§102351.1-102424
Other Standard *(specify):*
Licensing requirements listed under HSC 1596.95
The administrator shall have the following qualifications:
1. Attainment of at least 18 years of age.
2. Knowledge of the requirements for providing the type of care and supervision children need and the
ability to communicate with such children.
3. Knowledge of and ability to comply with applicable law and regulation.
4. Ability to maintain or supervise the maintenance of financial and other records.
5. Ability to establish the center's policy, program and budget.
6. Ability to recruit, employ, train, direct and evaluate qualified staff

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Family/Consumer Training

HCBS Taxonomy:

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

Service Definition *(Scope):*

Family/consumer support and training services are provided, as needed, in conjunction with extended state plan services in this waiver. These services include training by licensed providers to maintain or enhance the long-term impact of treatment provided. This includes support or counseling for the consumer and/or family to ensure proper understanding of the treatment provided and what supports are needed in the recipient's home environment to enhance the treatments. These services will be provided to individuals age 21 and older.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN,
Agency	Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist
Agency	Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN
Individual	Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family/Consumer Training

Provider Category:
Individual

Provider Type:
Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN,

Provider Qualifications

License *(specify):*

Occupational Therapist and Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Licensed Registered Nurse by the California Board of Registered Nursing pursuant to Business and Professions Code §§ 2725-2742

Licensed Vocational Nurse by the California Board of Vocational Nursing and Psychiatric Technicians pursuant to Business and Professions Code §§ 2859-2873.6 2873.7

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family/Consumer Training

Provider Category:
Agency

Provider Type:
Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist

Provider Qualifications

License *(specify):*
Occupational Therapist and Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Licensed Registered Nurse by the California Board of Registered Nursing pursuant to Business and Professions Code §§ 2725-2742

Licensed Vocational Nurse by the California Board of Vocational Nursing and Psychiatric Technicians pursuant to Business and Professions Code §§ 2859-2873.6 2873.7

As appropriate, a business license as required by the local jurisdiction where the business is located.
Dentist: Licensed Dentist by the Dental Board of California pursuant to Business and Professions Code§§1628-1636.6

Dental Hygienist: Licensed Dental Hygienist by the Dental Hygiene Committee of California pursuant to Business and Professions Code §§1900-1966.6

Marriage & Family Therapist (MFT): Licensed MFT by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4980-4989

Social Worker: Licensed Social Worker by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4996-4997.1

Speech Therapist: Licensed Speech-Language Therapist by the Speech-Language Pathology &

Audiology & Hearing Aid Dispensers Board pursuant to Business and Professions Code §2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family/Consumer Training

Provider Category:

Agency

Provider Type:

Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN

Provider Qualifications

License *(specify):*

Occupational Therapist and Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Licensed Registered Nurse by the California Board of Registered Nursing pursuant to Business and Professions Code §§ 2725-2742

Licensed Vocational Nurse by the California Board of Vocational Nursing and Psychiatric Technicians pursuant to Business and Professions Code §§ 2859-2873.6 2873.7

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family/Consumer Training

Provider Category:
Individual
Provider Type:
Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist
Provider Qualifications
License *(specify):*
Dentist: Licensed Dentist by the Dental Board of California pursuant to Business and Professions Code§§1628-1636.6

Dental Hygienist: Licensed Dental Hygienist by the Dental Hygiene Committee of California pursuant to Business and Professions Code §§1900-1966.6

Marriage & Family Therapist (MFT): Licensed MFT by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4980-4989

Social Worker: Licensed Social Worker by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4996-4997.1

Speech Therapist: Licensed Speech-Language Therapist by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board pursuant to Business and Professions Code §2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Housing Access Supports

HCBS Taxonomy:

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

Service Definition *(Scope):*

Housing Access Services includes two components:

A) Individual Housing Transition Services These services are:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
3. Assisting with the housing application process. Assisting with the housing search process.
4. Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses.
5. Coordinating resources to identify and address conditions in the living environment prior to move-in that may compromise the safety of the consumer.
6. Assisting with details of the move including communicating with the landlord to negotiate a move-in date, reading and understanding the terms of the lease, scheduling set-up of utilities and services, and arranging the move of consumers' belongings.
7. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

B) Individual Housing & Tenancy Sustaining Services - This service is made available to support individuals to maintain tenancy once housing is secured. The availability of ongoing housing-related services in addition to other long term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks. These tenancy support services are:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse

action.
5. Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized.
6. Assistance with the housing recertification process.
7. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
8. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.
Housing Access Services do not include payment for room and board

Persons receiving Health Homes or California Community Transitions services will not receive this service unless additional Housing Access through the waiver is necessary to maintain the consumers' health, safety and wellbeing in the home and/or community.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Business entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Access Supports

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Access Supports

Provider Category:

Agency

Provider Type:

Business entity

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Individual Training and Education

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Individual Training and Education Services includes training programs, workshops and conferences that assist the participant in acquiring and building skills related to his or her responsibility as an employer, relationship building, problem solving and decision making. This service helps the participate acquire skills that facilitate the participant's self-advocacy skills, exercise the participant's human and civil rights, and exercise control and responsibility over their SDP services and supports.
This service includes enrollment fees, books and other resource/reference materials required for participation in the individual training and education, and transportation expenses, excluding airfare, that are necessary to enable participation in the individual training and education. This service does not include the cost of meals or overnight lodging.
Individual Training and Education supports needs or goals identified in the participant's IPP.
This service is not provided when funding can be accessed through Public Education as required in IDEA (P.L. 105-17, the IDEA). Prior to accessing funding for this service, all other available and appropriate funding sources, including those offered by the Departments of Rehabilitation or Education must be explored and exhausted. These efforts must be documented in the participant's file.
This service does not duplicate the activities provided by the Independent Facilitator waiver service or Case Management. Neither case management nor the Independent Facilitator waiver service include the provision of training or the cost of enrollment fees. Furthermore, Independent Facilitators providers may not provide additional services to a participant. The Financial Management Services provider ensures compliance with this requirement.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Business entity

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Individual Training and Education

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Individuals must have a professional license, certification or registration by a nationally or state recognized entity, or demonstrated experience successfully providing this or similar services or demonstrated life experiences and skills to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Training and Education

Provider Category:

Agency

Provider Type:

Business entity

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Entities must have a professional license, certification or registration by a nationally or state recognized entity, if applicable, and demonstrated experience successfully providing this or similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Massage Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Massage Therapy is the scientific manipulation of the soft tissues of the body for the purpose of normalizing those tissues and consists of manual techniques that include applying fixed or movable pressure, holding, and/or causing movement of or to the body. Massage therapy would be provided to a participant as part of an effective continuum of care throughout the course of a medical condition.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Massage Therapist

Provider Category	Provider Type Title
Agency	Massage Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:
Individual
Provider Type:
Massage Therapist
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Certified by the California Massage Therapy Council (CAMTC). This is not a statewide requirement. However, if a professional holds this certificate they will not have to meet additional local requirements, if any

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:
Agency
Provider Type:
Massage Therapist
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Certified by the California Massage Therapy Council (CAMTC). This is not a statewide requirement. However, if a professional holds this certificate they will not have to meet additional local requirements, if any

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-Medical Transportation

HCBS Taxonomy:

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

Service Definition *(Scope):*
Service offered in order to enable individuals served to gain access to the Self-Determination Program waiver and community services, employment, activities and resources, and participate in community life as specified by their Individual Program Plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care and shall include transportation aides and such other assistance as is necessary to assure the safe transport of the recipient. Private, specialized transportation will be provided to those individuals who cannot safely access and utilize public transportation services (when available.) Whenever possible, the use of natural supports, such as family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.
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	Business entity
Individual	Individual

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Consultation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Nutritional consultation includes the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of participants. These services are consultative in nature and do not include specific planning and shopping for, or preparation of meals for participants.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity
Individual	Individual
Agency	Dietitian
Individual	Dietitian

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Agency

Provider Type:

Dietitian

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Valid registration as a member of the American Dietetic Association

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Individual

Provider Type:
Dietitian
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Valid registration as a member of the American Dietetic Association
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:
Participant-Directed Goods and Services

HCBS Taxonomy:

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

Service Definition *(Scope):*
Participant-Directed Goods and Services consist of services, equipment or supplies not otherwise provided through the SDP Waiver or through the Medicaid State plan that address an identified need in the IPP (including

accommodating, improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; promote interdependence, and inclusion in the community; and increase the person's safety in the home environment; and the participant does not have the personal funds to purchase the item or service and the item or service is not available through another funding source. The participant-directed goods and services must be documented in the participant's Individual Program Plan and purchased from the participant's Individual Budget. Experimental or prohibited treatments are excluded.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Business entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant-Directed Goods and Services

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant-Directed Goods and Services

Provider Category:
Agency

Provider Type:
Business entity

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

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

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

Service Definition *(Scope):*
PERS is a 24-hour emergency assistance service which enables the recipient to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed services to meet the needs and capabilities of the participant and includes training, installation, repair, maintenance, and response needs. The allowable service includes the following:
1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available free of charge from the telephone company;
10. Other devices/services designed for emergency assistance.

PERS services are limited to those individuals who have no regular caregiver or companion for periods of time, and who would otherwise require a greater amount of routine supervision. By providing immediate access to assistance, PERS services prevent institutionalization of these individuals and allow them to remain in the community. All Items shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers where possible.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response Provider
Individual	Personal Emergency Response Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Agency
Provider Type:
Personal Emergency Response Provider
Provider Qualifications
License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Individual

Provider Type:

Personal Emergency Response Provider

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:
Skilled Nursing

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Skilled nursing is only provided to individuals age 21 and over. All medically necessary skilled nursing services for children under the age of 21 are covered in the state plan pursuant to EPSDT benefit. Skilled nursing services will not supplant services available through the approved Medicaid State plan under the home health benefit or the EPSDT benefit

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Vocational Nurse (LVN)
Individual	Registered Nurse (RN)
Individual	Licensed Vocational Nurse (LVN)
Agency	Registered Nurse (RN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
Licensed Vocational Nurse (LVN)

Provider Qualifications

License *(specify):*
Business and Professions Code, §§ 2859-2873.7

Title 22, CCR, § 51069

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual

Provider Type:
Registered Nurse (RN)

Provider Qualifications

License *(specify):*
Professions Code §§2725 – 2742

Title 22, CCR, §51067

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
Licensed Vocational Nurse (LVN)
Provider Qualifications
License *(specify):*
Business and Professions Code, §§ 2859-2873.7

Title 22, CCR, § 51069

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency
Provider Type:
Registered Nurse (RN)
Provider Qualifications
License *(specify):*
Business & Professions Code §§2725 – 2742

Title 22, CCR, §51067

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Service Definition *(Scope):*
Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the IPP, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment and supplies not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. The repair, maintenance, installation, and training in the care and use, of these items is also included. Items reimbursed with waiver funds

are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design, and installation, and must meet Underwriter's Laboratory or Federal Communications Commission codes, as applicable. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Dealer

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Durable Medical Equipment Dealer

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located. If applicable, a current license with the State of California as appropriate for the type of equipment or supplies being purchased.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
If applicable, a current certification with the State of California as appropriate for the type of equipment or supplies being purchased.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

Technology is an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to promote community integration, independence, and increase, maintain, or improve functional capabilities of participants. Allowable technology services, as specified in the participant's IPP include:

1. Evaluation of technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate technology and appropriate services to the participant in the customary environment of the participant;
2. Purchasing, leasing, or otherwise providing for the acquisition of any technology device; including but not limited to cell phones (monthly bill, cell phone apps), iPads, tablets, laptops, GPS affixed to clothing (safety), service includes insurance and training on the use of any technology devices.
3. Acquiring remote monitoring equipment used to operate systems such as live video feed, live audio feed, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by the department. Equipment used to engage in live two-way communication with the individual being monitored.
4. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing technology devices;
5. Training or technical assistance for the participant, or where appropriate, their family members, guardians, advocates, or authorized representatives of the participant; and
6. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participant.

Technology may only be purchased under the SDP Waiver if it is not available through the state plan.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Technology

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Technology

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Training and Counseling Services for Unpaid Caregivers

HCBS Taxonomy:

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

Service Definition *(Scope):*

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, "individual" is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided to train paid caregivers. Training includes instruction about services and supports included in the IPP, use of equipment specified in the IPP, and updates as necessary to safely maintain the participant at home. Counseling must be

aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the IPP. The service includes the cost of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the IPP. The costs for travel, meals and overnight lodging to attend a training event or conference are not covered under this service definition. This service does not due duplicate the services provided under the waiver service Family/Consumer Training.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:
Transition/Set Up Expenses: Other Service

HCBS Taxonomy:

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

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

Service Definition *(Scope):*
Transition/Set Up Expenses are one-time, non-recurring set-up expenses to assist individuals who are transitioning from an institution to their own home in the community. These expenses fund some of the initial set-up costs that are associated with obtaining and securing an adequate living environment and address the individual's health and safety needs when he or she enters a new living environment. "Own home" is defined as any dwelling, including a house, apartment, condominium, trailer, or other lodging that is owned, leased, or rented by the individual. This service includes necessary furnishings, household items and services that an individual needs for successful transition to community living and may include:
• Security deposits that are required to obtain a lease on an apartment or home;
• Moving expenses;
• Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy;
• Set up fees or non-refundable deposits for utilities (telephone, electricity, heating by gas);
• Essential furnishings to occupy and use a community domicile, such as a bed, table, chairs, window blinds, eating utensils, food preparation items, etc.
These services exclude:
• Items designed for diversionary/recreational/entertainment purposes, such as hobby supplies, television, cable TV access, or VCRs and DVDs.
• Room and board, monthly rental or mortgage expense, regular utility charges, household appliances, and food.
Items purchased through this service are the property of the individual receiving the service and the individual takes the property with him/her in the event of a move to another residence. Some of these expenses may be incurred before the individual transitions from an institution to the community. In such cases, the Transition/Set Up expenses incurred while the person was institutionalized are not considered complete until the date the individual leaves the institution and is enrolled in the waiver. Transition/Set Up expenses included in the individual's plan of care may be furnished up to 180 days prior to the individual's discharge from an institution. However, such expenses will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition/Set Up Expenses: Other Service

Provider Category:

Agency

Provider Type:
Business entity
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition/Set Up Expenses: Other Service

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

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:

Vehicle Modifications and Adaptations

HCBS Taxonomy:

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

Service Definition *(Scope):*

Vehicle adaptations are devices, controls, or services which enable participants to increase their independence, enable them to integrate more fully into the community, and to ensure their health and safety. The repair, maintenance, installation, and training in the care and use, of these items are included. Vehicle adaptations must be performed by the adaptive equipment manufacturer's authorized dealer. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

Vehicle adaptations include, but are not limited to, the following:

1. Door handle replacements;
2. Door widening;
3. Lifting devices;
4. Wheelchair securing devices;
5. Adapted seat devices;
6. Adapted steering, acceleration, signaling, and braking devices; and
7. Handrails and grab bars

Adaptations to vehicles shall be included if, on an individual basis, the cost effectiveness of vehicle adaptations, relative to alternative transportation services, is established. Adaptations to vehicles are limited to vehicles owned by the recipient, or the recipient's family and do not include the purchase of the vehicle itself. The recipient's family includes the recipient's biological parents, adoptive parents, stepparents, siblings, children, spouse, domestic partner (in those jurisdictions in which domestic partners are legally recognized), or a person who is legal representative of the recipient. Vehicle adaptations will only be provided when they are documented in the individual plan of care and when there is a written assessment by a licensed Physical Therapist or a registered Occupational Therapist. The vehicle may be owned by the participant or a family member with whom he or she lives or has consistent and ongoing contact, who provides primary long-term support to the participant, and who is not a paid provider of such services.

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	Business entity
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications and Adaptations

Provider Category:
Agency
Provider Type:
Business entity
Provider Qualifications
License *(specify):*
No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Other Standard *(specify):*
Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.
Frequency of Verification:
Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications and Adaptations

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS and participant verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

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.*

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

Regional Centers

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):

Individuals who provide direct personal care services to participants are required to obtain a criminal background check consistent with the process described in Welfare and Institutions Code Sections 4689.2 to 4689.6. Additionally, a participant or their financial management service (FMS) provider may request

providers of other services and supports to obtain a criminal background check. FMS providers ensure that background checks for applicable service providers have been completed.

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

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

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

Appendix C: Participant Services

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

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

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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.

Relatives may provide any waiver service as long as the relative possesses the skill, training and/or education to provide the service and that the individual meets the provider qualifications specified for that service. Relatives are held to the same requirements that all providers must adhere to, as well as being subject to the monitoring requirements for the specified service.

○ **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:

Qualified providers are identified and enrolled by regional centers through the vendorization process. In accordance with state regulations, regional centers must verify, prior to the provision of services, that an applicant provider meets all of the requirements and standards specified in regulations. In accordance with Title 17 CCR Section 53422, the regional center is required to approve all qualified providers as long as the applicant provides all required information.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of licensed providers that initially meet all required standards prior to furnishing waiver services. Numerator = number of providers that initially meet all required standards prior to furnishing waiver services; denominator = number of all providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor Master File records indicate regional center verification of provider qualifications

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: Reviews are conducted at each	

	regional center (RC) every two years.	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers licensed by the Department of Social Services (DSS) reviewed annually. Numerator = number of DSS licensed providers reviewed annually; denominator = total number of providers licensed by DSS that require annual review.

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

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

Department of Social Services (DSS)		
	☐ **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: Department of Social Services	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: DHCS, DSS, and DDS meet quarterly to review issues concerning DSS licensed facilities

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

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

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

Performance Measure:
Number and percent of non-licensed/non-certified providers,including providers not vendored by the regional center, that continually meet all required standards. Numerator = number of providers that meet all required standards; denominator = number of providers reviewed.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of non-licensed/non-certified providers that initially meet all required standards prior to furnishing waiver services. Numerator = number of providers that initially meet all required standards; denominator = number of all providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
E-billing records indicate FMS verification of provider qualifications

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: Regional Centers FMS providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percent of direct support professionals (DSPs) that successfully complete 70 hours of competency based training within two years of hire. Numerator = number of DSPs who successfully complete the training; denominator = number of DSPs who attempt the training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSP Training Program Annual Report

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: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Individual issues identified during the SDP Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the State's recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the State's recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

All deficiencies noted during DSS inspections of licensed facilities result in the development of a plan of correction. All plans of correction require follow-up, which may include a repeat inspection, to ensure the plan was successfully completed.

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: DSS	☑ **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.

It is anticipated that most SDP participants will reside in the community in their own homes or in a housing unit that is rented or occupied under the State's landlord tenant laws. It's also anticipated that most SDP participants will choose to receive non-residential services in settings that 1) are not designed primarily or exclusively for the provision of services to individuals with disabilities and/or; 2) do not group or cluster individuals for the purpose of the provision of services. In these instances, the State presumes the settings meet the characteristics of home and community-based settings. The

regional center, financial management service provider and participant will jointly determine if a setting meets this presumption. All other settings, identified below, where participants choose to reside/receive services must be assessed to determine compliance with the HCB settings requirements prior to payment for services received in these locations.
Participants may choose to reside and receive services in any of the following residential settings:
• Residential Care Facility for the Elderly
• Small Family Home
• Certified Family Home
• Adult Residential Care Facility for Persons with Special Health Care Needs
• Foster Family Home
• Group Home
• Adult Residential Facility

Participants may also choose to receive services in the following non-residential settings:
• Facility-based settings
o Activity Center
o Adult Day Care Facility
o Adult Development Center
o Behavior Management Program
• Any community-based location in which multiple individuals are grouped or clustered for the provision of services.

For participants that choose to reside or receive services in the settings identified above, the setting must conform with the following:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
5. Facilitates individual choice regarding services and supports, and who provides them.

In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:
6. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

7. Each individual has privacy in their sleeping or living unit:
• Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
• Individuals sharing units have a choice of roommates in that setting.
• Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

8. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
9. Individuals are able to have visitors of their choosing at any time.
10. The setting is physically accessible to the individual.
11. The unit or dwelling may be shared by no more than four waiver participants.
12. Any modification of the additional conditions specified in items 6 through 9 above, must be supported by a specific assessed need and justified in the individual program plan (IPP). The following requirements must be documented in the IPP:

• Identify a specific and individualized assessed need.
• Document the positive interventions and supports used prior to any modifications to the IPP.
• Document less intrusive methods of meeting the need that have been tried but did not work.
• Include a clear description of the condition that is directly proportionate to the specific assessed need.

• Include regular collection and review of data to measure the ongoing effectiveness of the modification.
• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
• Include the informed consent of the individual.
• Include an assurance that interventions and supports will cause no harm to the individual.
Compliance with the standards above is a requirement for SDP providers. Prior to the provision of SDP services, the IPP planning team (regional center representative and the SDP participant), in conjunction with the financial management services (FMS) provider and the service provider chosen by the participant, will conduct an assessment of any of the settings identified above chosen by an SDP participant, to determine the standards are met. The assessment will include a review and verification that each of the standards identified above are met as applicable for the type of setting. The assessment process will be as follows:
• The service provider chosen by the participant will complete a self-assessment of the setting, using a standardized tool, developed as part of the State's transition planning, which aligns with the federal requirements highlighted previously
• The regional center, in conjunction with the consumer, FMS provider and service provider, will conduct an on-site assessment of the setting using a standardized tool, developed as part of the State's transition planning, which aligns with the federal requirements highlighted previously.
• This assessment will include a review of the settings policies/procedures for alignment with the HCBS requirements.
• Results of the assessment will be documented on the standardized tool and maintained by the regional center, FMS and provider
• The assessment will also indicate any setting requirements that initially were not met and the actions taken in response.
• On-going monitoring of compliance with the HCBS settings requirements will occur in the following ways:
o During required on-site monitoring visits of licensed residential facilities
o During the on-site State waiver monitoring reviews where a representative, random number of consumers are selected for review. This review includes on-site visits to settings where consumers receive services
o During annual IPP reviews. The IPP planning team will review the initial assessment and current operations of the setting to verify that the standards identified above continue to be met as applicable for the type of setting. Documentation of this review will be maintained by the regional center and FMS.

The FMS provider will not approve payments to any applicable providers that are not deemed in compliance with the standards included in this Appendix. Participants will receive training on the HCBS settings requirements as part of the required SDP Orientation

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Program Plan (IPP)

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:

  The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.
- ☐ **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.

(a) The service plan, commonly referred to as the individual program plan (IPP), is developed through a process of individualized needs determination, which includes gathering information from providers of services and supports, and is prepared jointly by the planning team. Each participant is central in the service plan development process and is paired with a case manager to assist in the IPP development. Information available for supporting recipients in the IPP process includes, but is not limited to, the following documents, all of which are available using the links below or through the DDS website at www.dds.ca.gov:
1. "Individual Program Plan Resource Manual" – This resource manual is designed to facilitate the adoption of the values that lead to person-centered individual program planning. It is intended for use by all those who participate in person-centered planning. It was developed with extensive input from service recipients, families, advocates and providers of service and support.
2. "Person-Centered Planning" – This publication consists of excerpts taken from the Individual Program Plan Resource Manual to provide recipients and their families information regarding person-centered planning.
3. "From Conversations to Actions Using the IPP" – This booklet shares the real life stories of how recipients can set their goals and objectives and work through the IPP process to achieve them.
4. "From Process to Action: Making Person-Centered Planning Work" – This guide provides a quick look at questions that can help a planning team move the individual program plan from process to action focusing on the person and the person's dreams for a preferred future.

(b) The IPP planning team, at a minimum, consists of the participant, and where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and an authorized regional center representative. With the consent of the participant, other individuals, including service providers, may receive notice of the meeting and participate in the development of the IPP.

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 IPP is developed by the planning team through a process of individualized needs determination. The planning team, at a minimum, consists of the participant, and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and the regional center case manager. With the consent of the participant/ conservator, other individuals, including but not limited to, Financial Management Service (FMS) providers and other service providers, may receive notice of the meeting and participate in the development of the IPP.
The IPP development process includes gathering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers to community integration, and concerns or problems of the participant. For children, this process includes a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments are conducted to identify potential health needs (medical, dental, and mental health), as well as behavioral and safety risks that may require the development of mitigation strategies. Information to aide in the assessment is obtained from the participant, his or her parents and other family members, his or her friends, advocates, providers of services and supports, and other agencies. The assessment process reflects awareness of, and sensitivity to, the lifestyle and cultural background of the participant and the family.

Utilizing information obtained during the assessment process, the IPP is prepared jointly by the planning team, which includes at minimum the consumer, legal representative or designee and the regional center service coordinator. Decisions regarding goals, objectives, needed services and providers of services are made with the agreement of the planning team. The goals included in the IPP, and objectives to implement those goals, are based on the consumer's needs, preferences and life choices. The IPP identifies the providers responsible for implementing services that address the agreed upon goals and objectives. The IPP includes all services, including those purchased by the participant using their SDP individual budget or obtained from generic resources. The receipt of these services is coordinated by the IPP planning team during the planning process to ensure any needed services available through generic resources are provided prior to accessing available waiver services. The required SDP orientation includes a review of available SDP and generic services. Additionally, the planning process includes a review of available services based on the participant's needs.

The regional center service coordinator is assigned the responsibility to monitor and oversee implementation of the IPP. The IPP is reviewed at least annually and, when needed, modified by the planning team at a time and location that is convenient to the participant. The annual review of the IPP will often include the development of a new IPP. In some cases, a new IPP is completed biennially or triennially. If a new IPP is not completed annually, case managers will continue to use the DDS "Standardized Annual Review" form to document the annual review of the consumer's IPP, CDER and health status. If new services or supports are needed, the IPP will be amended to include the new services or supports. The planning team members will sign the "Standardized Annual Review" form to document that the remainder of the IPP remains appropriate to meet the consumer's needs. If no new services or supports are required, the planning team will indicate that the IPP remains appropriate to meet the consumer's needs.

Regardless of the planned schedule for review and modification of the IPP, a review of the IPP can be requested at any time and will be modified in response to the consumer's needs upon agreement of the planning team. The comprehensive person-centered planning includes the development of an individual budget that is based on the amount of purchase of service (POS) funds used by the individual in the most recent 12-months and can be adjusted, up or down, if the IPP team determines that the individual's needs, circumstances, or resources has changed. Additionally, the IPP team may adjust the budget to support prior needs or resources that were not addressed in the IPP. For those individuals that are new to the regional center or do not have a 12-month history of purchase of service costs, the individual budget amount is determined by the IPP team, and is based upon the average POS cost of services and supports, paid by the regional center, that are identified in the individual's IPP. The completed individual budget must be attached to the IPP. [WIC §4685.8(k)].

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 IPP person-centered planning process includes an assessment of risk and identification of mitigation strategies as necessary. With input from the State's independent risk management contractor, DDS distributed a tool that can be used to aid the IPP planning team in identifying risk factors and developing interventions to minimize risks. Individual risk and safety considerations are identified during the person-centered planning process. Potential interventions that promote interdependence, independence and safety with the informed involvement of the participant are included in the IPP when the planning team agrees that it is an identified need.

The IPP will include, as needed, services to assist in responding to emergencies or other unusual situations. Available services may include 24-hour emergency assistance, such as direct service in response to calls for assistance. These services may also include assisting and facilitating the participant's efforts to acquire, use, and maintain devices needed to summon immediate assistance when threats to health, safety, and well-being occur. Additionally, support to become aware of and effectively use the police, fire, and emergency help available in the community is available.

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 are informed about the types of services available in the self-determination program (SDP) and strategies for selecting providers during the required SDP orientation and through available trainings. Additionally, through the person-centered planning process, the case manager informs the participant and/or his or her legal representative about available services that meet the participant's needs. Participants may meet with service providers before selecting services to be incorporated into the IPP. The participant's choice of providers includes consideration of, among other things, the provider's ability to achieve the objectives set forth in the participant's IPP.

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):

As part of the biennial SDP Waiver monitoring reviews, a representative, random sample of participant IPPs is reviewed to ensure all service plan requirements have been met. The statewide sample size, as determined using a sample size calculator such as Raosoft, will be a statistically representative sample of participants enrolled in the waiver, yielding a 95% confidence level with a 5% margin of error. The Department of Health Care Services will either participate in the biennial monitoring reviews with DDS or conduct a review of DDS' monitoring working documents.

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:

Regional Center

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.

Regional center case managers are responsible for monitoring the implementation of all consumer IPPs. At least annually, all IPPs are reviewed to determine that planned services have been provided, that sufficient progress has been made on the consumers' goals and objectives, and that consumers and families are satisfied with the individual program plan and its implementation.

For consumers who do not live with their families, quarterly face-to-face monitoring is required to monitor the consumer's health, safety and well-being, asses the effectiveness of services and monitor progress in meeting the identified goals.

Further, as part of the SDP Waiver monitoring reviews, a representative sample of consumer IPPs is reviewed to ensure IPP implementation monitoring is being completed. If during the State reviews significant issues are identified, the regional center has 30 days to respond to DDS with completed/planned resolution. If there is an immediate health and safety concern, the response is expected at the time the issue is identified. Systemic information is collected during the State biennial SDP Waiver monitoring reviews. Other avenues that issues may be reported to the State include those detailed in Appendix F.

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 State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of reviewed individual program plans (IPPs) that adequately addressed all of the consumers' assessed needs. Numerator = number of consumer IPPs reviewed that addressed all assessed needs. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of consumer IPPs that addressed all of the consumer's identified health needs and safety risks. Numerator = number of consumer IPPs reviewed that addressed all of the consumers' identified health needs and safety risks. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of consumer IPPs that addressed all of the consumer's goals. Numerator = number of consumer IPPs reviewed that addressed all of the consumers' goals. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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 consumer records that documented the individual budget was determined appropriately (consistent with WIC Section 4645.8 (n-p)). Numerator = number of consumer records reviewed that documented the individual budget was determined appropriately. Denominator = total number of consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:
Number and percent of consumer IPPs that were reviewed or revised at required intervals (at least annually). Numerator = number of consumer IPPs that were reviewed or revised at required intervals. Denominator = total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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:
Number and percent of participants who received services, including the type, scope, amount, duration and frequency, specifically identified in the IPP. Numerator = number of consumers who received services that matched the services identified in the IPP. Denominator = total number of IPPs reviewed.

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

Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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:

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:
Number and percent of IPPs that that are signed by the consumer/parent/legal representative indicating agreement with the services and providers identified in the IPP. Numerator = number of IPPs that are signed by the consumer/parent/legal representative. Denominator = total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields

		results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of records that contain documentation the consumer was afforded the choice between/among waiver services and providers Numerator = number of consumer records that document consumer was afforded the choice between/among waiver services and providers. Denominator = total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Individual service plan issues identified during the SDP Waiver Monitoring Reviews will be documented in monitoring reports which will be sent to the regional centers with the State's recommendations for resolution. The regional centers plans for correction submitted in response to the State's recommendations will be evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**
○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The SDP Waiver is designed to afford participants the opportunity to self- determine and directly manage all services and supports identified in their IPP. Utilizing a person-centered planning process, the participant and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, regional center case manager, Financial Management Services (FMS), and Independent Facilitator (IF) (when requested by the participant) shall identify the services and supports that will meet their needs.

The SDP Waiver provides the participant with both Budget Authority and Employer Authority. The Budget Authority provides the participant, or his or her parents, legal guardian or conservator, or authorized representative, with decision-making authority over a budget for waiver services. Each participant shall exercise Budget Authority over all participant-determined services in the IPP. The Employer
Authority provides the mechanism for a participant to exercise the full-range of decision-making about whom he/she will employ.

The planning team, including the participant, his or her parents, legal guardian or conservator, or authorized representative, regional center case manager, FMS, and IF (when requested by the participant) shall support the participant in the selection and self-determining of services and supports to implement their IPP. Specific types of supports provided by the FMS and IF are described in Appendix C-3.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☑ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Participant direction opportunities will also be available to participants who live in other living arrangement that facilitate independence and promote community integration. These include the following settings that have a capacity for no more than four (4) residents:
Adult Residential Facility
Adult Residential Facility for Persons with Special health Care Needs
Certified Family Home; Foster Family Home
Group Home; Small Family Home
Residential Care Facility for the Elderly
Two other community living arrangement setting types are Adult Family Homes which have a capacity for no more than two (2) residents, and Family Teaching Homes which have a capacity for no more than three (3) residents.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ◉ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

As part of SDP outreach efforts, each regional center, jointly with consumer or family-run organizations, conducts periodic local meetings or forums to provide information about the SDP Waiver to participants and families.

When an individual or family expresses interest in participating in the SDP Waiver, a mandatory orientation is provided to the participant by their local regional center prior to enrollment in the SDP. This orientation is designed to prepare the individual for the benefits and increased responsibilities associated with the self-determination service-delivery model, as well as to provide information regarding transitioning to the SDP Waiver. Among the topics to be included in the required orientation are the principles of self-determination, the person-centered planning process, the IPP and individual budget development, the roles and responsibilities of the participant, and that of the regional center, Financial Management Services (FMS) provider, the independent facilitator, and SDP service providers.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants (or their authorized, legal representative) have the opportunity to choose who may assist them in directing their services. The participant determines the extent the assistance/decision making that a non-legal representative may provide. Safeguards that ensure a non-legal representative functions in the best interest of the participant include regular monitoring of the participant's IPP (as described in Appendix D) and individual budget by the regional center service coordinator. This monitoring is done to determine if satisfactory progress is being made toward the objectives identified in the IPP and the satisfaction with services and providers. Regular reports provided by FMS providers also allow for oversight of budget expenditures and identification of potential issues.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Non-Medical Transportation	☑	☑
Transition/Set Up Expenses: Other Service	☐	☑
Training and Counseling Services for Unpaid Caregivers	☐	☑

Waiver Service	Employer Authority	Budget Authority
Technology	☑	☑
Vehicle Modifications and Adaptations	☑	☑
Prevocational Supports	☑	☑
Home Health Aide	☑	☑
Physical Therapy	☐	☑
Occupational Therapy	☐	☑
Family/Consumer Training	☑	☑
Family Support Services	☑	☑
Acupuncture Services	☐	☑
Communication Support	☑	☑
Employment Supports	☑	☑
Behavioral Intervention Services	☑	☑
Massage Therapy	☐	☑
Chiropractic Service	☐	☑
Crisis Intervention and Support	☑	☑
Community Living Supports	☑	☑
Community Integration Supports	☑	☑
Homemaker	☑	☑
Financial Management Service	☑	☑
Environmental Accessibility Adaptations	☑	☑
Dental Services	☑	☑
Individual Training and Education	☑	☑
Housing Access Supports	☑	☑
Independent Facilitator	☑	☑
Optometric/Optician Services	☐	☑
Nutritional Consultation	☑	☑
Live-In Caregiver	☑	☑
Lenses and Frames	☑	☑
Respite Services	☑	☑
Psychology Services	☑	☑
Personal Emergency Response Systems (PERS)	☐	☑
Participant-Directed Goods and Services	☑	☑
Speech, Hearing and Language Services	☐	☑
Specialized Medical Equipment and Supplies	☐	☑
Skilled Nursing	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The FMS assists the participant to manage and direct the distribution of funds contained in the individual budget, and ensure that the participant has the financial resources to implement his or her Individual Program Plan (IPP) throughout the year.

This service includes the following activities to assist the participant in their role as either the employer or co-employer:
1. Assisting the participant in verifying worker's eligibility for employment and provider qualifications
2. Ensuring service providers employed by the participant meet criminal background checks as required and as requested by the participant.
3. Collecting and processing timesheets of workers.
4. Processing payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
5. Tracking, preparing and distributing reports (e.g., expenditure) to appropriate individual(s)/entities.
6. Maintaining all source documentation related to the authorized service(s) and expenditures.
7. Maintaining a separate accounting for each participant's participant-directed funds.
8. Providing the participant and the regional center service coordinator with a monthly individual budget statement that describes the amount of funds allocated by budget category, the amount spent in the previous 30-day period, and the amount of funding that remains available under the participant's individual budget.
9. Ensuring payments do not exceed the amounts outlined in the participant's individual budget
10. Fulfilling other FMS responsibilities as mandated by local, state and federal laws and regulations.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The costs of financial management services shall be paid by the participant out of his or her individual budget. The amount of the individual budget shall not be increased to cover the cost of an independent facilitator or the financial management services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [ ] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

FMS providers are subject to periodic random audits by both regional centers and DDS. Additionally, specified providers pursuant to State law must obtain an independent audit or review or their financial statements annually. The results and accompanying management letters must be forwarded to the appropriate regional center. Subsequently, the regional center must require resolution of issues identified in the reports and notify DDS of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services. Further, a sample of claims at each regional center is reviewed as

part of the biennial regional center audits conducted by DDS and reviewed by Department of Health Care Services (DHCS).

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

All participants have an assigned regional center case manager. Case managers furnish the following types of information and assistance in support of participant self-determination:
• Facilitate the development of the individual program plan (IPP.)
• Provide information related to orientation, training and technical assistance with respect to self-determination and other resources available through the regional center or from other sources in the community so the participant can make an informed decision about the self-determination method of service delivery.
• Review and document the participant's progress to achieving IPP objectives and management of individual beget.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Non-Medical Transportation	☐
Transition/Set Up Expenses: Other Service	☐
Training and Counseling Services for Unpaid Caregivers	☐
Technology	☐
Vehicle Modifications and Adaptations	☐
Prevocational Supports	☐
Home Health Aide	☐
Physical Therapy	☐
Occupational Therapy	☐
Family/Consumer Training	☐
Family Support Services	☐
Acupuncture Services	☐
Communication Support	☐
Employment Supports	☐
Behavioral Intervention Services	☐
Massage Therapy	☐
Chiropractic Service	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Crisis Intervention and Support	☐
Community Living Supports	☐
Community Integration Supports	☐
Homemaker	☐
Financial Management Service	☐
Environmental Accessibility Adaptations	☐
Dental Services	☐
Individual Training and Education	☐
Housing Access Supports	☐
Independent Facilitator	☑
Optometric/Optician Services	☐
Nutritional Consultation	☐
Live-In Caregiver	☐
Lenses and Frames	☐
Respite Services	☐
Psychology Services	☐
Personal Emergency Response Systems (PERS)	☐
Participant-Directed Goods and Services	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Skilled Nursing	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

All individuals who receive services through regional centers have access to independent advocacy provided by the Office of Client's RightsAdvocacy (OCRA) which is within California's protection & advocacy organization, Disability Rights California (DRC). This service is available through a contract funded by the California Department of Developmental Services. OCRA employs Clients Rights Advocates (CRA) who provide advocacy services to consumers and their families in each regional center catchment area. The CRAs have been trained to assist people with developmental disabilities in the protection of their rights. The CRA can consult with and help people with developmental disabilities and their families obtain services; directly represent people with developmental disabilities in administrative hearings; and provide training about rights to participants, their families, regional center service providers, and interested community groups. DRC does not provide other direct services or perform other waiver functions that have a direct impact to self-determination participants.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A participant may voluntarily terminate participation in the SDP Waiver at any time. The participant shall notify the regional center case manager of his/her decision to no longer participate in the SDP Waiver and the case manager shall inform the participant of available alternatives.

When the participant expresses interest in receiving alternative services, the regional center case manager shall arrange to convene the IPP planning team to develop a new IPP and initiate actions necessary to transition the individual to the selected alternative. The case manager shall review the current IPP to determine the services that the participant is receiving and consult with the participant or parent, legal guardian or conservator, or authorized representative, to identify the services and supports that are vital to assuring the participant's health and welfare during the interim period until the new IPP is finalized and the participant selects providers vendored through the regional center.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individual will be involuntarily terminated from the SDP Waiver if the individual no longer meets eligibility criteria.
When the regional center determines that involuntary termination is necessary, the case manager shall inform the participant of available alternatives for obtaining services and supports. The case manager shall review the current IPP to determine the services that the participant is receiving and consult with the participant or parent, legal guardian or conservator, or authorized representative, to identify the services and supports that are vital to assuring the participant's health and welfare during the interim period until the new IPP is finalized and the participant selects providers vendored through the regional center. The regional center case manager shall assure that there will be no gaps in services during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1000
Year 2		2500
Year 3		2500

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

FMS Co-Employer entities function as legal employers in collaboration with family members or participants, acting as Co-Employers. The FMS Co-Employer must possess the ability to collect and process employee time records, assist family members or participants, acting as Co-Employers, in verifying the worker's eligibility for employment, process payroll, withholding, filing and payment of applicable federal, state and local employment related taxes and insurance, prepare and distribute monthly expenditure reports to the Co-Employer and the regional center; maintain all source documentation related to the authorized service(s) and expenditures, maintain separate accounting of funds used for each adult consumer or family member, and ensure payments do not exceed the amounts and rates authorized. A review of all IPP services, including the FMS, is a part of all periodic (quarterly and/or annually) IPP reviews. The IPP will identify when the FMS and participant are co-employers.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☑ **Recruit staff**
- ☑ **Refer staff to agency for hiring (co-employer)**
- ☐ **Select staff from worker registry**
- ☑ **Hire staff common law employer**
- ☑ **Verify staff qualifications**
- ☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The provider incurs the cost of criminal history and/or background investigations.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including

how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individual budget is determined by the IPP team, and is based upon the amount of purchase of service funds used by the participant in the most recent 12-months. This amount can be adjusted, up or down, if the IPP team determines that the participant's needs, circumstances, or resources has changed. Additionally, the IPP team may adjust the budget to support any prior needs or resources that were not addressed in the IPP. For a participant who is either newly eligible for regional center services or who does not have 12 months of purchase of service expenditures, the budget is based upon the average cost of services and supports paid by the regional center that are identified in the individual's IPP. The average cost may be adjusted, up or down, by the regional center, if needed to meet the individual's unique needs. This methodology is available in state statute (Welfare in Institutions Code Section 4685.8 (n-p) as well as the Department's SDP website.) Consistent application of this methodology is reviewed during the State's biennial monitoring reviews.

Services in the Waiver are grouped into the budget categories specified below. This grouping is only for the purpose of budgeting as outlined in state statute which states that a participant may transfer up to 10 percent of the funds distributed to any budget category to another budget category. Transfers in excess of 10 percent can be made with approval of the IPP planning team.

The budget categories are:
• Living Arrangements
• Employment and Community Participation
• Health and Safety

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Prior to enrollment in the SDP Program, and based upon the methodology described above, the regional center provides the prospective SDP Waiver participant an initial individual budget amount. During the IPP development process, the consumer selects services and supports available in the SDP waiver to implement their IPP. Each year, the regional center shall determine whether there are any circumstances that require a change in the amount of the budget. An adjustment may be made to the budget as the participant's circumstances, needs, and resources change. As described in Appendix F, participants are afforded the opportunity to request a fair hearing when the participant's request for a budget adjustment is denied or the amount of the budget is reduced.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The SDP Waiver participant has the authority and flexibility to modify and reallocate services and a support to achieve the desired outcomes described in the IPP and has the ability to reallocate funds within budget categories.

Annually, the participant may transfer up to 10 percent of the funds originally distributed to any budget category to another budget category or categories, without prior approval. Transfers in excess of 10 percent of the original amount allocated to any budget category may be made upon the approval of the regional center or the participant's IPP team.

Changes to the participant's budget are documented by the FMS and reflected in the participant's IPP.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS provides the participant and the regional center service coordinator with a monthly individual budget statement that describes the amount of funds allocated by budget category, the amount spent in the previous 30-day period and the amount of funding that remains available under the participant's individual budget. These budget statements can be used to help identify potential issues that may require a review or modification to either the individual budget or individual program plan. FMS providers and regional center service coordinators have roles in monitoring utilization of participants' individual budgets. State law provides for upward adjustment of budgets when a participant's circumstances, needs, or resources, or if prior unaddressed needs, resulted in an increase. FMS providers are responsible for tracking, preparing, and distributing expenditure reports. Regional centers are responsible for holding quarterly face-to-face meetings with participants. Participants can choose to include family members and independent facilitators in these meetings. These safeguards allow for potential budget problems are identified on a timely basis.
The State's biennial review process includes reviewing the safeguards identified above. This monitoring provides the state Medicaid agency with data regarding potential service delivery or oversight issues that may be associated with or lead to problems with individual budget utilization.

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.

As required by the State Medicaid Manual (SMM) §2900.1, Self-Determination Program participants are afforded the right to a fair hearing if there is a disagreement with any actions taken by the regional center including the following; denial of eligibility, termination or reduction in services, denial of choice of services, denial of chosen provider, or disagreement with the amount of service. Pursuant to 42 CFR 431.206 and SMM §2900.2, information (in 12 different languages) regarding the fair hearing process, including related forms and a brochure describing the process, are available at http://www.dds.ca.gov/complaints/complt_fh.cfm. Additionally, this information is provided to every participant in a notice whenever any of the events described previously occur. Regional centers are required to provide fair hearing information to the participant. All participants and persons having legal responsibility for participants will be informed verbally of, and will be notified in writing in a language which they comprehend, the service agency's mediation and fair hearing procedure

when they apply for service, when they are denied service, when notice of service modification is given, and at any time upon request.

Notice will be sent to the applicant or recipient and the authorized representative by certified mail at least 30 days prior to any of the following actions: (1) The regional center makes a decision without the mutual consent of the service recipient or authorized representative to reduce, terminate, or change services set forth in an individual program plan, or; (2) A recipient is determined to be no longer eligible for agency services.
Notice will be sent to the applicant or recipient and the authorized representative by certified mail no more than five working days after the agency makes a decision without the mutual consent of the recipient or authorized representative, to deny the initiation of a service or support requested for inclusion in the individual program plan.

Regional centers are required to provide written notice informing the applicant, recipient, and authorized representative of information on the availability of advocacy assistance, including referral to the regional center clients' rights advocate, the State Council on Developmental Disabilities, publicly funded legal services corporations, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under federal Public Law 95–602, the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. Sec. 6000 et seq.). Regional center employees are required to assist applicants/ recipients/authorized representatives with filing the fair hearing request and filling out forms when requested.

Fair hearing brochures, notification of resolution, and fair hearing request forms are maintained at each regional center and are available on the DDS' website at www.dds.ca.gov. Regional centers and vendors that contract with a regional center to provide services to recipients are required to noticeably post on their websites, if any, a link to the DDS website page that provides a description of the appeals procedure, and a DDS telephone number for recipients and applicants who have questions about the appeals procedure.

If a participant requests a fair hearing, a number of options are available to resolve the disagreement. The participant may request an informal meeting with the regional center, or mediation. Consistent with SMM §2902.1, these steps are optional and do not take the place of the State level fair hearing. The participant may choose to go straight to the fair hearing or may choose to try resolution at either an informal meeting or mediation. Even if the participant initially chooses one of these two options, they may at any time choose to proceed to the fair hearing.

As required by 42 CFR 431.230, if a participant requests a fair hearing, services will not be terminated or reduced until a decision is rendered. Fair hearings are conducted by independent hearing officers with the State's Office of Administrative Hearings (OAH.) By State statute, and consistent with SMM §2903.5, the Director of DHCS, the State Medicaid Agency, has delegated his authority to adopt final decisions to the Director of OAH.

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:

The Department of Developmental Services

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).

Pursuant to the California Welfare and Institutions Code, § 4731, a participant may pursue a Consumer Complaint if the participant believes the regional center or service provider has violated any rights they are entitled to under the law. The initial referral of the complaint shall be to the Executive Director of the regional center. Upon receipt of the complaint, the Executive Director has 20 working days to investigate the matter and send a written proposed resolution to the participant or representative. If the participant or representative is not satisfied with the proposed resolution, the participant or representative shall refer the matter in writing to the Director of the DDS within 15 working days of receipt of the proposed resolution. The Director shall, within 45 days of receiving the complaint, issue a written administrative decision, and send a copy of the decision to the participant and Executive Director of the regional center.

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).

DDS has promulgated regulations that describe special incident reporting (SIRs) requirements and define the incident types that require a SIR, including:
• The participant is missing and a missing persons report has been filed with a law enforcement agency
• Reasonably suspected abuse/exploitation including physical, sexual, fiduciary, emotional/mental, or physical/chemical restraint.

• Reasonably suspected neglect including failure to provide medical care for physical and mental health needs, prevent malnutrition or dehydration, protect from health and safety hazards, assist in personal hygiene or the provision of food, clothing or shelter or exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult.
• A serious injury/accident including lacerations requiring sutures or staples, puncture wounds requiring medical treatment beyond first aid, fractures; dislocations, bites that break the skin and require medical treatment beyond first aid, internal bleeding requiring medical treatment beyond first aid, any medication errors, medication reactions that require medical treatment beyond first aid, or burns that require medical treatment beyond first aid.
• Any unplanned or unscheduled hospitalization due to the following conditions: respiratory illness, including but not limited, to asthma, tuberculosis, and chronic obstructive pulmonary disease; seizure-related; cardiac-related, including but not limited to, congestive heart failure, hypertension, and angina; internal infections, including but not limited to, ear, nose and throat, GI, kidney, dental, pelvic, or urinary tract; diabetes, including diabetes-related complications; wound/skin care, including but not limited to, cellulitis and decubitus; nutritional deficiencies, including but not limited to, anemia and dehydration; or involuntary psychiatric admission; unplanned hospitalizations.
• Deaths, regardless of cause.
• The participant is a victim of a crime including the following: robbery, including theft using a firearm, knife, or cutting instrument or other dangerous weapons or methods which force or threaten a victim; aggravated assault, including a physical attack on a victim using hands, fist, feet or a firearm, knife or cutting instrument or other dangerous weapon; larceny, including the unlawful taking, carrying, leading, or riding away of property, except for motor vehicles, from the possession or constructive possession of another person; burglary, including forcible entry; unlawful non-forcible entry; and, attempted forcible entry of a structure to commit a felony or theft therein; or rape, including rape and attempts to commit rape.

Service providers vendored by the regional centers are required to report a SIR to the regional center within 24 hours after learning of the incident occurrence. The initial report may be by telephone; however, a written report with specified information (as outlined in Title 17 § 54327) must be submitted to the regional center within 48 hours of learning of the incident occurrence.
Regional centers, in turn, are mandated by Title 17, §54327.1 to submit SIRs (via the State's electronic SIR system) to DDS within two working days following initial receipt of the incident report or within two working days of learning of the incident.

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.

DDS has overall state-level responsibility for planning, coordinating and overseeing implementation of the State's risk mitigation and management system for persons with developmental disabilities, of which training and education is a component.

Both DDS and the State's independent risk management contractor provide regional centers and/or qualified providers training and technical assistance on the legal obligations in abuse reporting; SIR documentation requirements; the definition of 'special incident'; best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process. This training and education to regional center staff and providers enables these entities to disseminate training and education materials to consumers/families on abuse, risk assessment and mitigation. Further, regional centers, pursuant to Title 17 §54327.2, must have a risk management and mitigation plan that addresses training for various parties mentioned above that is monitored by an internal risk management, assessment and planning committee.

Training and information in this area will occur as part of the orientation for SDP. Training through the orientation will include how no notify the appropriate entities when a participant has experienced abuse, neglect or exploitation On-going monitoring, for example through quarterly and or annual review of the IPP, may identify a need for more frequent or additional training needs.

The State's independent risk management contractor develops and disseminates training materials, newsletters, and a website (DDS Safety Net) on various subjects in consumer-friendly format relative to staying safe, keeping healthy, etc. In addition, regional centers are provided quarterly analysis and trends on their SIR data by the independent risk

management contractor, allowing regional centers to develop and implement focused strategies to mitigate emerging trends in the SIR data.

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.

Regional centers receive the initial SIR from appropriate entities and in turn report the SIR to DDS. As appropriate, licensing and/or protective services entities are notified by the regional center. The timelines for initial SIR reporting are outlined in G-1-b.

SIR Evaluation, Examination and Follow-up
Regional centers have local-level responsibility for evaluation, examination and follow-up of SIRs. Regional centers are required to report special incidents and follow-up activities to DDS via the electronic SIR system. Regional centers are required to pursue follow-up activities until there is a satisfactory resolution of the immediate issue and mitigation of future risk to participants. Upon receipt of the special incident report, the regional center:
1. Reviews the incident report, ensures participant's safety and contacts the participant's authorized representative, as appropriate.
2. Reports the incident to investigative/protective services agencies, as appropriate.
3. Enters the initial information into special incident reporting system within two working days of learning of the incident.
4. Engages in activities to protect the participant's health and welfare and to prevent future incidents.
5. Records medical and other health related care received by the participant for his/her significant medical conditions in the period prior to the special incident.
6. Reviews medical records and coroner reports to ensure appropriate medical attention was sought and/or given.
7. Coordinates with other agencies (e.g., licensing, protective services, law enforcement agencies, coroners, long-term care ombudsman, etc.) to gather and review the results of their investigations and using this information to prevent the recurrence of similar problems.
8. Conducts on-site and chart review activities to gather and report initial and follow-up SIR information.
9. Adds required information to the initial SIR within 30 working days following initial report and updates SIR on a flow basis.
10. Closes the SIR when all required information and all follow-up activities are completed and entered into the electronic reporting system.

DDS Report Review and Evaluation Process
DDS has state-level responsibility for evaluation and follow-up of SIR reports; DDS evaluates and follows up on special incidents by:
1. Daily reviews of SIR transmissions to ensure regulatory compliance and proper notifications have been made to legally required entities, and that appropriate follow-up activities are occurring. Immediate follow-up with regional centers is conducted, as needed, to ensure consumer health and safety has been assured.
2. Aggregating and analyzing SIR data by certain characteristics (i.e., regional centers, providers, incident types, residence and other relevant factors) on an ad-hoc basis.
3. Providing input to the State's independent risk management contractor for further analysis and to regional centers for follow-up as appropriate.

Regional centers are required to report additional information to DDS within 30 days of receiving the SIR, but this timeframe does not apply a requirement that the investigation must be completed by that time. The requirement is that the regional center must add information on a flow basis and close the SIR when all required information and all follow up activities are completed and entered into the electronic reporting system. DDS has a well-established follow-up system to track "open" SIRs. The system includes regular contact with the regional center.

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.

DDS has overall state-level responsibility for planning, coordinating and overseeing the implementation of the State's risk management program for persons with developmental disabilities, including those that are SD Waiver participants. DDS carries out this responsibility by:
1. Developing, implementing and maintaining a uniform, statewide automated SIR database system.

2. Reviewing daily all individual SIRs to identify issues or concerns requiring additional follow-up.
3. Revising regulations as needed related to SIR requirements to address new system requirements.
4. Conducting periodic, on-site monitoring visits to review regional center and provider compliance with SIR regulatory requirements, as well as ensuring consistent and accurate reporting.
5. Aggregating and analyzing SIR data by regional centers, risk indicators, client characteristics, programs, incident types, corrective actions, residence, and other relevant factors. Providing such data to the risk management contractor for further analyses and to regional centers for follow-up, as appropriate.
6. Providing training and technical assistance to regional centers on legal obligations in abuse reporting; documentation requirements; the definition of "special incident;" best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process.
7. Preparing, implementing and managing the risk assessment and mitigation contract.
8. Reviewing on-site highly unusual, suspicious and/or very sensitive individual incidents where DDS Headquarters involvement is indicated.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

California prohibits using restraint(s) on any person with a developmental disability, pursuant to CCR, Title 17 §50515 unless applicable licensing regulations regarding the use of bodily restraints are strictly adhered to and approved by the State's licensing entity, DSS CCL. Pursuant to Ca. Health and Safety Code § 1180.4(b), Group homes and Community Care Facilities may use behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others. Please note that this citation references general licensing laws, however, pursuant to CCR, Title 17 §50515(a), seclusion is prohibited for a person with a developmental disability.
Restraints may be used only in an emergency, typically known as behavioral restraints, to protect the participant and others from injury and after alternative procedures have been attempted and failed. As defined in Health and Safety Code Section 1180.1, "Behavioral restraint" means "mechanical restraint" or "physical restraint" as defined in this section, used as an intervention when a person presents an immediate danger to self or to others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure, or postural restraints, or devices used to prevent injury or to improve a person's mobility and independent functioning rather than to restrict movement.
Per Health and Safety Code 1180.4, the following types of restraints are prohibited:
• Restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back.
• A pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint

or containment process.
• Physical or mechanical restraint or containment on a person who has a known medical or physical condition and there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition.
• Prone mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors that are known to the provider:(A) Obesity,(B) Pregnancy,(C) Agitated delirium or excited delirium syndromes,(D) Cocaine, methamphetamine, or alcohol intoxication, (E) Exposure to pepper spray,(F) Preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders,(G) Respiratory conditions, including emphysema, bronchitis, or asthma.
• Placing a person in a facedown position with the person's hands held or restrained behind the person's back.
An Emergency Intervention Plan is developed by the facility and approved by the Department of Social Services (DSS) prior to the use of manual restraints specifying the less restrictive or non-physical de-escalation methods that may be used to identify and prevent behaviors that lead to the use of manual restraint. Pursuant to CCR, Title 22 § 85322, the Emergency Intervention Plan shall include:
1) Staff qualifications sufficient to implement the plan
2) A list of job titles of the staff required to be trained to use manual restraint
3) A list of emergency intervention techniques beginning with the least restrictive intervention with a description of each emergency intervention technique that may be used;
4) A description of the circumstances and the types of client behaviors for which the use of emergency interventions are needed;
5) Procedures for maintaining care and supervision and reducing the trauma of other clients when staff are required for the use of emergency interventions;
6) Procedures for crisis situations, when more than one client requires the use of emergency interventions simultaneously;
7) Procedures for re-integrating the client into the facility routine after the need for an emergency intervention has ceased;
8) Criteria for assessing when an Emergency Intervention Plan needs to be modified or terminated;
9) Criteria for assessing when the licensee does not have adequate resources to meet the needs of a specific client;
10) Criteria for assessment when community emergency services are necessary to assist staff during an emergency intervention;
11) Procedures to ensure a client in crisis does not injure or endanger self or others;
12) Criteria for assessing when an Individual Emergency Intervention Plan needs to be modified or terminated;
13) A statement clarifying that only trained staff may use emergency interventions.
All instances of restraints are required to be reported to CDSS and the regional center and subsequently to DDS.

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:

Oversight of the use of restraints is conducted by both CDSS and DDS. As noted previously, all instances of restraints are required to be reported to CDSS and the regional center and subsequently to DDS. Reports can be made verbally and follow written reports are also required. Data on all incidents including the use of restraints, is used to identify trends that may indicate a need for further intervention. The State's risk management contractor assists DDS and regional centers in the development of reports that identify trends and strategies used to identify potential factors influencing these trends. DDS uses these trend reports to identify instances that may require further follow up and continues to monitor these trends and the results of mitigating actions taken. The risk management contractor develops these reports quarterly.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The unauthorized use of restrictive interventions is monitored in the SDP Waiver through:
• Daily of review of special incident reports by regional centers
• Quarterly monitoring visits conducted by the regional center service coordinator and the ongoing contact with the participant by the service coordinator.
• Annual or unannounced visits by CCL.

○ **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 unauthorized use of seclusion is monitored in the SDP Waiver through:
• Quarterly monitoring visits conducted by the regional center case manager and the ongoing contact with the participant by the case worker.
• Annual or unannounced visits by DSS CCL.

In California, the discovery of the unauthorized use of seclusion would result in the cancellation of the contract of the responsible provider. A special incident report would be filed with the regional center and licensing/law enforcement agencies (if applicable) which would investigate and take action. DDS would be notified of any outcomes pursuant to the special incident reporting process.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For consumers who reside in community living arrangements where the provider has round-the-clock responsibility in residences that are not the participant's own home or home of a family member, the following entities have responsibility for monitoring those living arrangements:

• The consumer's prescribing physician (ongoing)
• Person-centered planning team through their monitoring of the IPP (as needed, and annually at a minimum.)
• Regional centers' monitoring of provider compliance with assisting the consumer in receiving medical care and medication management follow-up pursuant to the IPP (as needed, and quarterly at a minimum.)

Further, the State's mandated statewide competency-based training for direct support professionals employed in regional center vendored community care facilities has modules on medication management, including training on appropriate handling/dispensing of medications.

The State monitors medication management through the State's overall risk mitigation and management system as well as the Waiver Monitoring Review. Further, medication management is monitored by the Regional Center through Title 17 California Code of Regulations and through Department of Social Services' Community Care Licensing Division requirements. The State's risk management contractor reviews electronic SIR data for trends in medication errors and hospitalizations due to medication errors. This data is reported to DDS on a quarterly basis where DDS uses it to determine statewide priorities for risk management activities, e.g. system level remediation and quality improvement initiatives including: regional center technical support, publication of mitigation tools and information on the website.

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.

The State monitors medication management through the activities which include (but are not limited to), the State's overall risk mitigation and management system and Waiver Monitoring Reviews. The State's risk

management contractor reviews electronic special incident report data for trends in medication errors and unplanned hospitalizations due to medication errors and reports the results to DDS at least quarterly. As part of its contract with DDS, the risk management contractor also performs polypharmacy reviews and follow-up. Technical assistance and/or tools are developed on an as needed basis in response to SIR trends to prevent the occurrence of incidents. Further, in the state mandated DSP training (for all direct support professionals employed in regional center vendored community care facilities); there is a component on medication management.
Additionally, if the provider is licensed by the Department of Social Services - Community Care Licensing (CCL), a review of medication policies/procedures is conducted. CCL and regional centers monitor ongoing thereafter through oversight and monitoring activities to address any issues relative to medication management.

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).

For applicable providers, all of the State's licensing and certification comprehensive requirements (CCR, Title 22) are in effect, including, but not limited to §§80075 and/or 87575.

Additionally, the State's mandated statewide competency-based training for direct support professionals employed in regional center vendored community care facilities has modules on medication management, including training on appropriate handling/dispensing of 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:

  Pursuant to state regulations, all medication errors for participants who are under a provider's care are required to be reported to (1) the regional center and (2) the appropriate State licensing entity.

  Regional centers, in turn, are required to notify DDS of medication errors.

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

  Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

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

  Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Regional centers monitor the provider's compliance with medication administration pursuant to the IPP, via service coordinator and quality assurance site visits as needed and through special incident reporting. The State monitors these requirements through reporting of special incidents by regional centers as well as at least quarterly analysis and reporting by the State's risk management contractor.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of special incidents reported within required timeframes.
Numerator =number of special incidents reported with required timeframes;
denominator =number of special incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database.

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: Regional Centers	☐ **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: Regional centers, independent risk management contractor	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received training/information on how to recognize and report instances of abuse, neglect or exploitation. Numerator = number of participants who received training/information in the identified areas; denominator = total number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Consumer record reviews conducted during on-site SDP Waiver Monitoring Reviews

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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 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:
Number and percent of special incidents for which appropriate actions were taken. Numerator =number of special incidents for which appropriate actions were taken; denominator=number of special incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database.

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: Regional Centers, Special incident report (SIR) database	☐ **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: Regional centers, independent risk management contractor	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:

Number and percent of instances in which state policies regarding restrictive intervention were followed. . Numerator=number of special incidents reported on use of restrictive interventions in which state policies were followed; denominator = total number of special incidents reported on use of restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database.

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: regional centers	☑ **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):*
Regional centers, independent risk management contractor	
	☑ **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:
Number and percent of consumers whose special health care requirements or safety need are met. Numerator=number of consumers whose special health care requirements or safety needs are met; denominator = total number of consumers reviewed with special health care requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields

		results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of consumers who received recommended health related follow-up activities. Numerator=number of consumers who received recommended health related follow-up activities; denominator = total number of consumers reviewed with recommended health related follow-up activities

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews.

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

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.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Individual issues (e.g. appropriateness, timeliness, etc.) identified during the SDP Waiver Monitoring Reviews will be documented in monitoring reports which will be sent to the regional centers with the State's recommendations for resolution. The regional centers plans for correction submitted in response to the State's recommendations will be evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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;
- 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 2)

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.

California has excellent systems and structures in place that provide information and/or guide the quality improvement strategy (QIS). These include the risk management and mitigation system, regional center performance contracts, the Waiver Monitoring Reviews, biennial regional center fiscal audits, and the direct support professional (DSP) training program. All of these components are based on the quality model that starts with establishing clear expectations for performance (design), collecting data to determine if the expectations are met (discovery), taking steps to correct deficiencies (remediation), and utilizing information obtained to implement improvements and continuously monitor the system to determine if desired results were achieved (improvement).

While all the various aspects of the QIS have built-in continuous quality monitoring, trend identification, remediation and improvement responsibilities, it is important to get a coordinated, comprehensive look at the performance of all aspects of the service delivery system. To that end, the state has established the Quality Management Executive Committee (QMEC) consisting of executive level personnel from both DHCS and DDS. The involvement of DHCS in the QMEC ensures that the State Medicaid agency is actively involved in the assessment of waiver performance. One of the main functions of the QMEC is to analyze data and trends identified through the multiple discovery activities and sources described in this and other sections throughout this application. This analysis enables the QMEC to assess the efficacy of the system's design, discovery, remediation, and improvement activities. As a result of this analysis, the QMEC is able to prioritize suggested policy changes or system enhancements that may be necessary in response to identified trends.

As an example, the following is a more detailed description of the process employed by the QMEC in trend identification and coordination of system enhancement activities utilizing information from one component of the QIS. Although the design, discovery, remediation and improvement activities vary for each of the QIS components, the process described below is representative of the QMEC's role in identifying the need for and coordinating system improvements.

The State puts a premium on protecting consumers' health and welfare. This is evidenced by the commitment to establishing and overseeing a multi-faceted risk management and mitigation system. As a key component in this system, the State engages the services of an independent, specialized risk management and mitigation contractor possessing a multidisciplinary (clinical, research, data analysis, training, business) capacity. One of the responsibilities of this contractor is to analyze information from the State's electronic special incident reporting system. The QMEC uses the contractor's statistical analysis of incident report data and other related data sets to help determine statewide priorities and direct risk management activities. Remediation and system improvement activities directed by the QMEC include targeted technical assistance for regional centers experiencing an increase in incidents; working with a group of regional center risk management personnel in an effort to gather better actionable data; technical support in the development of remediation plans; modification of the State's required direct support professionals training for individuals employed in community care facilities; and development of mortality review guidelines and medical diagnosis checklists for common chronic conditions.

When the need for potential system enhancements is identified by the QMEC, the process often involves changes to existing regulation, statute and/or budgetary authority. Each of these steps requires that public input is sought before any changes are made. For example, the rules for promulgation of new regulations require the solicitation of public comments on the proposed regulations. Additionally, numerous legislative hearings are conducted during the development of the State's annual budget. Public testimony, both oral and written, is taken at these hearings which are historically widely attended and participated in by stakeholders (e.g. consumers, families and service providers) when issues concerning the service system for people with developmental disabilities are discussed. DDS has also historically convened workgroups and/or held public forums to obtain input from stakeholders in developing proposals for system changes.

Stakeholder participation in this process is also accomplished through the Consumer Advisory Committee (CAC). This standing committee consists of individuals who are members of and have been nominated by a local People First or self-advocacy group. The purpose of the CAC is to advise DDS on issues involving

policies, programs, legislation, and regulations affecting the delivery of services and supports to people with developmental disabilities in California. In addition, DDS discusses issues, including new or potential policy changes with the CAC and ensures that appropriate DDS representatives attend CAC meetings based on the topics that are to be discussed.

The overall QIS for the self-determination program is consistent with the strategy used for the State's 1915(c) wavier (CA.0336) for people with developmental disabilities and the 1915(i) state plan amendment. However, data is collected so that it is reported separately to CMS for each of these programs.

ii. System Improvement Activities

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

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 QIS is designed to incorporate continuous quality monitoring of all SDP Waiver assurances. This enables the State to utilize data from the various discovery activities for the purpose of performing on-going assessments of the QIS, including the effectiveness of any system enhancements. As described in the previous section, the Quality Management Executive Committee (QMEC) has the primary role in making a coordinated system assessment. This includes assessing the effectiveness of system enhancements and the design of new discovery activities if needed. It is important to note that the multiple QIS discovery activities include input from and on-going communication with stakeholders, including consumers/families, service providers, regional center staff and State representatives. How system assessments are communicated with stakeholders is described below:

Regional Center Performance Contracts – Performance contracts measure progress on public policy and compliance measures for each regional center. These contracts are developed through a public process that includes input on performance objectives. Examples of these measures include the number of minors residing with families; the number of adults residing with their families, in independent or supported living, or Family Home Agency homes; compliance with DDS and independent fiscal audits; and compliance with individual program plan development requirements. The data for the measures in each contract is provided to regional centers every six months, including a year-end final report that is available to the public.

Independent Risk Management Contractor Activities – The risk management contractor produces and distributes a number of reports that are used to assess system improvement activities. These include: quarterly reports of increased incident occurrences and subsequent regional center responses to these increases; semi-annual reports of statewide incident trends which are posted on the DDS website; and an annual report to the legislature on statewide incident trends and remediation activities. Further, the risk management contractor participates, along with DDS representatives, in quarterly meetings with regional center risk management personnel as well as the training subcommittee of the regional centers Chief Counselor's committee (see below). These regular meetings provide a forum for reviewing the efficacy of systems improvements.

Regional Center Committees – DDS meets regularly with groups of regional center representatives who are organized in a number of topic and/or function specific standing committees. These committees include the regional center Chief Counselors (case management executives), risk management representatives, and Waiver personnel (i.e. qualified intellectual disability professionals). Participation in these committees affords DDS and regional center stakeholders' regular opportunities to review and communicate about system performance and SDP Waiver related policies. DDS' regular participation in these committees is a mechanism through which TA is provided, implementation and compliance issues discussed, and communication regarding system issues and performance occurs.

Regional Center Boards of Directors – As private, non-profit entities, each regional center is governed by a board of directors. The composition of these boards requires the inclusion of persons with developmental disabilities or family members/legal guardians. Additionally, each board must have an advisory committee comprised of a wide variety of providers of regional center services. These boards conduct regular public meetings and are tasked with the oversight of all regional center activities. This includes the review and implementation to the previously discussed regional center performance contracts. The composition requirements of the boards, in addition to the public nature of their activities, ensure that stakeholders have the opportunity to provide input on and receive information regarding regional center policies and system changes.

Consumer Advisory Committee (CAC) – The CAC, described above, meets quarterly and collaborates with DDS. During these meetings, DDS discusses and disseminates information on topics raised by CAC members, including new or potential policy changes.

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

The Quality Management Executive Committee (QMEC) is able to continuously evaluate the design of the QIS strategy due to the on-going nature of the discovery, remediation and improvement activities described in this application. In addition, the State utilizes information from national advocacy and provider organizations, other states, and CMS to identify potential design changes that would strengthen the QIS.

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).

DDS performs fiscal audits of each regional center every two years, and completes follow-up audits of each regional center in alternate years or more frequently as needed. Regional centers are also required to contract with independent auditors to conduct an annual audit. DDS reviews each regional's centers annual independent audit report and follows up with the regional center regarding corrective action for each management comment identified in the independent auditor's report. DDS also conducts audits of service providers.

Additionally, specified providers pursuant to State law must obtain an independent audit or review or their financial statements annually. The results and accompanying management letters must be forwarded to the appropriate regional center. Subsequently, the regional center must require resolution of issues identified in the reports and notify DDS of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services.

DDS conducts fiscal compliance audits of vendors in compliance with the Generally Accepted Government Auditing Standards (GAGAS). The types of audits conducted focus on the consumer services billed to the regional centers. The vendor audits are to ensure fiscal compliance, accurate billings to the regional centers, verification that services were provided and to provide information to improve operations and facilitate decision-making by parties with responsibility to oversee or initiate corrective action and improve public accountability. Multiple types of supporting documentation are reviewed to verify that services were rendered. This includes but is not limited to time sheets, staff

schedules, progress/update notes, etc. The participant, in the role of employer/co-employer is involved in verifying/approving time sheets that are submitted to the FMS for payment.

The scope of vendor audits, including audits resulting from whistleblower complaints, includes reviewing the billings, appropriate rates, appropriate credentials or licenses, and internal controls.

In determining the audit plan and methodology, the auditors obtain an understanding of the internal controls as it relates to the specific objectives and scope of the audit. Then, based upon a risk assessment and review of internal controls, the auditor will determine the audit sample period (Time Period) to meet the audit objectives. There are no set time requirements for how often vendors are to be audited. Vendor audits are chosen by DDS using various factors, such as the size of the service provider/vendor, amount of claims and information obtained from regional centers. Additionally, vendors may be referred to DDS audits based on whistleblower complaints.

As described below, DDS coordinates its activities with DHCS A&I.
DHCS maintains on-going oversight of the audit functions of this Waiver as follows:
1. DHCS Audits and Investigations (A&I) reviews DDS regional center Pre-Audit Review Package which contains: DDS' contracts and Contract Budget Summaries; summary of regional center budget; summary of state claims; summary of advances and offsets; independent audit reports and management letters; regional center response to management letters; and DDS review of independent audit work papers.
2. DHCS A&I reviews DDS draft regional center audit reports and notifies DDS if material findings are noted.
3. DHCS A&I participate in vendor audit entrance/exit conferences as appropriate.
4. DHCS A&I review draft DDS vendor audit reports and audit working papers.
5. DHCS submits annual report of DHCS A&I's oversight activities to CMS.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percentage of claims coded and paid in accordance with the reimbursement methodology in the approved waiver. Numerator = number of claims coded and paid in accordance with the reimbursement methodology in the approved waiver; denominator = total number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Biennial Regional Center 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** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Fiscal audits are conducted at each regional center every two years. Follow-up fiscal audits are conducted annually or more frequently as needed.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS audits of regional center vendors

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: DDS fiscal vendor audits are conducted based on a random sample of vendors with annual expenditures over $100,000 or upon referral.
	☐ **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 claims paid in accordance with the participant's individual program plan. Numerator = number of claims paid in accordance with the consumer's individual program plan; denominator = total number of claims for participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of consumers who were enrolled on the waiver prior to the generation of claims for federal reimbursement. Numerator = number of consumers who were enrolled on the waiver prior to the generation of claims for federal reimbursement; denominator = total number of consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's SDP Waiver Monitoring Reviews

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 = State wide sample size determined using sample size calculator that yields results with a 95%confidence level with a 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state 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:

Number and percent of claims paid at the approved service rate. Numerator = Number of claims paid at the approved service rate. Denominator = Total number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS audits of Regional Center claims

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Individual issues identified during any of the audit and oversight activities above require corrective actions to be developed by either the regional center or vendor. These corrective actions are evaluated and approved by DDS and included in the final audit reports. DHCS provides oversight of this process.

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).

Rates for all services, with the exception of financial management services, are negotiated between the waiver participant and each provider selected by the participant. When the participant is the sole employer of an individual who provides a service to the participant, the wage rates negotiated must comply with applicable federal, state and local minimum wages. The maximum monthly rates for financial management services established by DDS are based on the number of services participants utilize. Should there be any changes in the rate methodology the State will undergo public comment process. Information about payment rates will be made available to waiver participants via pre-enrollment informational meetings, during the SDP orientation as well as the online posting of the approved waiver application.

In developing the proposed rate methodologies, the Department has received input from the Self-Determination Program Workgroup was formed in December 2013. Workgroup members consist of an array of stakeholders including consumers, family members, service providers, and representatives of regional centers, advocacy groups, and the State Council on Developmental Disabilities. Since its formation, the Workgroup has assisted DDS in shaping the framework of the Self-Determination Program based on the law in which it is authorized. Meetings have been open to the public where input was welcomed and received.

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:

Claims for services provided are submitted to regional centers by the FMS entity selected by the participant. These claims are subsequently submitted to DDS, the Organized Health Care Delivery System (OHCDS) for this Waiver. Under an interagency agreement with DHCS, DDS prepares and submits invoices to DHCS for valid, reimbursable costs (see item I-2-d.)

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.)*

DDS, with DHCS oversight, certifies that the public expenditures for waiver services are based on the total costs of services provided to the participant. By using the methods described in items I-2-d and I-3-a, DDS ensures that only those costs are 1) provided to eligible individuals, and 2) for services identified in

the waiver, are included on invoices sent to DHCS to claim FFP. As detailed in item I-1, claims for waiver services are subjected to regular periodic audits and reviews by State, regional center and independent auditors.

☐ **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:

The SDP Waiver employs a multi-tiered billing validation process. Claims submitted by participant-selected or participant-employed providers are reviewed by FMS providers to ensure the services are included in the participant's individual program plan.

Regional centers subsequently transmit all claims received from FMS providers to DDS through a system of main frame computers. At DDS the expenditures are processed to determine if:
1. The service recipient (consumer) was enrolled on the Waiver at the time of service.
2. The consumer was eligible for Medi-Cal at the time of service.
3. The service provided is eligible for FFP.
A claim for FFP is only completed if all three of the conditions above are met.

FMS providers develop monthly expenditure reports for regional centers and participants. These reports not only provide updated tracking of total expenditures within the participant's budget, but also provide a chance to review claims made by providers to ensure they are in line with the participant's IPP.
Regional Centers/FMS providers maintain supporting documentation of services claimed. DDS fiscal audits review supporting documentation, including the IPP, monthly claims (including dates of service) and the periodic reports mentioned in the previous response. During the biennial reviews, DDS reviews invoices, attendance, and other supporting documentation to ensure that services have been rendered.
Regional Centers report dates that participants are admitted to nursing facilities so that billing does not occur for services during the time that the participant is in a nursing facility.

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 to providers for authorized services are processed through the Uniform Fiscal System (UFS). The system establishes and tracks regional center authorization and billing data including vendor (provider) number, consumer identification and eligibility information, claim amount, and claim date. Waiver services will not be paid unless the appropriate billing data are present. Regional centers transmit to DDS all billing data necessary to support the provider claims to provide a complete audit trail. Regional center vendors, regional centers and DDS are required to maintain documentation to support financial accountability in accordance with federal requirements. In addition to the controls contained in UFS to prevent possible erroneous payments, oversight of appropriate claiming also includes provider audits conducted by regional centers and DDS.

Only claims determined valid by DDS through the process described in item I-2-d are submitted to DHCS for FFP and reporting as 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:

DDS, as the operating agency and Organized Health Care Delivery System (OHCDS) for this Waiver, acts as the limited fiscal agent for all waiver services. In this role, through processes described previously, DDS verifies the appropriateness of claims submitted by regional centers and submits invoices to DHCS for FFP. The requirements for DDS in this role, as well as the financial accountability oversight responsibility of DHCS, are outlined in an interagency agreement between DHCS and DDS.

☐ **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:

(a) Waiver services will be reimbursed through an Organized Health Care Delivery System (OHCDS) operated by DDS, which is the enrolled Medicaid provider for these services. DDS provides Medicaid services (outside the waiver) through its operation of state developmental centers. SDP waiver and case management services are provided through 21 private non-profit entities known as regional centers which are under contract with DDS to coordinate, counsel, advocate and arrange for individualized services and supports for people with developmental disabilities and their families.
(b)The DDS OHCDS is an open network. Regional centers evaluate and approve prospective FMS providers through a process referred to as "vendorization." The purpose of vendorization is to ensure that the provider meets DDS and SDP waiver qualifications and is enrolled in the regional center payment system. The regional centers do not have the ability to contract selectively or otherwise restrict the number of FMS providers reimbursed for DDS services. Qualifications of providers other than FMS are verified by the participant and the FMS.
(c) Consumers select their providers through the development and implementation of an individual program plan ("IPP"). A consumer is not limited to FMS providers already vendored by the regional center. If a consumer selects another FMS provider, that FMS provider is then vendored to ensure that it meets provider qualifications and is enrolled in the regional center's payment system.
(d) DDS establishes the qualifications for FMS providers. The regional centers, as agents of DDS, are responsible for ensuring that FMS providers meet all applicable qualifications. If they do, they are then vendored and included in the OHCDS.
(e) DDS is responsible for overseeing the operation of the OHCDS. This includes assuring that the regional centers review the qualifications of all FMS providers (through the vendor process) and require FMS providers to meet all applicable Medicaid requirements (e.g., the maintenance of necessary documentation).
(f) The regional centers pay enrolled FMS providers based on the submission of claims. DDS then reimburses the regional centers for these expenditures, plus administrative expenses based on time studies. DDS certifies these expenditures to DHCS for reimbursement of the federal share. There is no "mark up" of expenditures. The amount that the DDS OHCDS bills for Waiver services equals the amount that it reimburses the regional centers plus its administrative costs.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **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.**

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:

DDS directly incurs the full cost of waiver services. The non-federal share for these costs is appropriated directly to DDS through the State budget process. The source of all non-federal, or matching, funds used in computing the waiver costs is from State revenues. Therefore, no federal funds are used to match other federal funds.
As described in item I-2-c, the total amount paid for waiver services is submitted to DHCS by DDS via certified public expenditures as the basis for claiming of FFP.

☐ **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 licensed residential settings, the waiver participant (or representative payee) pays the facility directly for the provision of room and board from his/her SSI/SSP income, retaining the Personal Needs Allowance. The facility submits claims to the FMS for the services received.

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:

The maximum payment for the rent and food expenses of a live-in personal caregiver is the sum of: (a) one-half of the most-recent published federal Housing and Urban Development (HUD) Fair Market Rent (FMR) for a two-bedroom living unit in the geographic area where the participant resides and (b) the current United States Department of Agriculture (USDA) maximum food stamp allowance for a single individual.

The payment for the caregiver will go through the provider but clearly provide for the reimbursement of the participant. The FMS shall pay these charges to the live-in caregiver who, in turn, will compensate the participant.

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: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10136.42	7224.00	17360.42	34038.00	4899.00	38937.00	21576.58

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)
2	14184.15	10114.00	24298.15	47653.00	6859.00	54512.00	30213.85
3	20263.13	15762.00	36025.13	76492.00	10690.00	87182.00	51156.87

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

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:
		ICF/IID
Year 1	1000	1000
Year 2	2500	2500
Year 3	2500	2500

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) is estimated based on actual experience for services provided to persons enrolled on the Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS DD Waiver).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

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 for these estimates is as follows:

The Factor D utilization factors for waiver services are based on actual expenditures and unduplicated users as reported on the CMS 372 report for 2015/16 for services provided to persons enrolled on the HCBS DD Waiver. The per capita cost, by service, was trended forward to the number of persons who will be served during years 1 through 3. Utilization adjustments take into account the ALOS calculation above. The Therapeutic/Activity-Based Day Services $50 monthly rate was based on costs for Sports Club. The Therapeutic/Activity-Based Day Services $40 hourly rate was based on costs for Specialized Recreational Therapy, Music Therapist, and Recreational Therapist. The estimate for Technology is based on costs from the Assistive Technology service in Pennsylvania Waiver and discussions with the California stakeholders group, $1,200/unit was estimated and 10% of participants were assumed to utilize this service. The number of eligible recipients was estimated by starting in year one with 1,000, and increasing caseload to 2,500 in years 2 and 3. Estimates of eligible recipients by service for each proposed year of the Waiver were based on the ratio of actual recipients of service to the total for the 2015/16 CMS 372 reporting period. The estimate of 2,500 eligible recipients is based on W&I Code, Section 4685.8 that states that the statewide SDP shall be phased in over 3 years, and during the phase-in period, shall serve up to 2,500 RC consumers. It was estimated that 1,000 would participate in the first year, and 2,500 in the second year. It was assumed that the enrollment of the initial 1,000 consumers in year 1 would result in an average length of stay (ALOS) of 5.5

months. In year two, it was assumed that these 1,000 consumers would have an 11 month ALOS (based on experience current HCBS Waiver) while the additional 1,500 consumers enrolled would have an ALOS of 5.5 months. This results in an estimated total of 19,250 months of participation, divided by 2,500 consumers equals 7.7 months ALOS. The factor of 1.4 is the result of dividing 7.7 by 5.5. In year 3, since there is no longer any phased enrolling, the ALOS is estimated to be 11 months (e.g. 11 divided by 5.5 equals 2.)

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

Factor D' equals the average per capita annual costs for all other Medicaid services (ancillary) to HCBS DD Waiver recipients (excluding HCBS DD Waiver costs). These estimates are based on actual costs as reported on the CMS 372 report for 2015/16.

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

Factor G equals the estimated annual average per capita Medicaid cost for ICF/MR care that would be incurred for individuals served in the Waiver, were the Waiver not granted. Factor G estimates for inpatient intermediate care facility LOC are based on actual costs as reported on the CMS 372 report for 2015/16.

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

The Factor G’ estimates for State Plan services utilization for inpatient intermediate care facility, level of care are derived from experience as reported on the CMS 372 report for 2015/16.
Other assumptions used for obtaining the aggregate Factor G’ waiver are described below.
• The cost of all State Plan services furnished during an inpatient stay.

• 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 7)

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	
Community Living Supports	
Employment Supports	
Homemaker	
Live-In Caregiver	
Prevocational Supports	
Respite Services	
Acupuncture Services	
Chiropractic Service	
Dental Services	
Home Health Aide	
Lenses and Frames	
Occupational Therapy	
Optometric/Optician Services	
Physical Therapy	
Psychology Services	
Speech, Hearing and Language Services	
Financial Management Service	
Independent Facilitator	
Behavioral Intervention Services	
Communication Support	

Waiver Services	
Community Integration Supports	
Crisis Intervention and Support	
Environmental Accessibility Adaptations	
Family Support Services	
Family/Consumer Training	
Housing Access Supports	
Individual Training and Education	
Massage Therapy	
Non-Medical Transportation	
Nutritional Consultation	
Participant-Directed Goods and Services	
Personal Emergency Response Systems (PERS)	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Technology	
Training and Counseling Services for Unpaid Caregivers	
Transition/Set Up Expenses: Other Service	
Vehicle Modifications and Adaptations	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

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
Community Living Supports Total:						**2333130.90**
Licensed/Certified Residential Services	Month	31	5.50	3252.82	**554605.81**	
Supported Living Services	Hour	85	793.17	26.38	**1778525.09**	
Employment Supports Total:						**17601.87**
Supported Employment	Hour	9	53.48	36.57	**17601.87**	
Homemaker Total:						**21802.07**
Homemaker	Hour	8	150.65	18.09	**21802.07**	
Live-In Caregiver Total:						
				GRAND TOTAL:		**10136417.03**
				Total Estimated Unduplicated Participants:		**1000**
				Factor D (Divide total by number of participants):		**10136.42**
				Average Length of Stay on the Waiver:		6

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						625350.00
Live-In Caregiver	Month	150	5.50	758.00	**625350.00**	
Prevocational Supports Total:						**268866.19**
Prevocational Supports	Day	70	107.68	35.67	**268866.19**	
Respite Services Total:						**722114.24**
In Home Respite Care	Hour	385	99.13	18.64	**711396.53**	
Out-of-Home Respite Care	Day	5	29.42	72.86	**10717.71**	
Acupuncture Services Total:						**6435.00**
Acupuncture Services	Hour	9	11.00	65.00	**6435.00**	
Chiropractic Service Total:						**1490.28**
Chiropractic Service	Hour	2	11.00	67.74	**1490.28**	
Dental Services Total:						**5878.84**
Dental Services	Visit	18	0.86	379.77	**5878.84**	
Home Health Aide Total:						**42545.03**
Home Health Aide	Hour	7	321.58	18.90	**42545.03**	
Lenses and Frames Total:						**380.74**
Lenses and Frames	Piece	1	4.55	83.68	**380.74**	
Occupational Therapy Total:						**1724.95**
Occupational Therapy	Hour	2	17.71	48.70	**1724.95**	
Optometric/Optician Services Total:						**111.64**
Optometric/Optician Services	Hour	2	0.57	97.93	**111.64**	
Physical Therapy Total:						**1724.95**
Physical Therapy	Hour	2	17.71	48.70	**1724.95**	
Psychology Services Total:						**735.50**
Psychology Services	Hour	2	8.80	41.79	**735.50**	

GRAND TOTAL:	**10136417.03**
Total Estimated Unduplicated Participants:	**1000**
Factor D (Divide total by number of participants):	**10136.42**
Average Length of Stay on the Waiver:	6

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech, Hearing and Language Services Total:						**2598.20**
Speech, Hearing and Language Services	Hour	4	11.81	55.00	**2598.20**	
Financial Management Service Total:						**261305.00**
Financial Management Service	Month	1000	5.50	47.51	**261305.00**	
Independent Facilitator Total:						**723520.00**
Independent Facilitator	Hour	700	8.00	129.20	**723520.00**	
Behavioral Intervention Services Total:						**295278.25**
Behavioral Intervention Services	Hour	86	59.90	57.32	**295278.25**	
Communication Support Total:						**5368.83**
Communication Support	Hour	13	9.62	42.93	**5368.83**	
Community Integration Supports Total:						**3824628.70**
Community-Based Day Services (Day)	Day	440	92.92	70.82	**2895461.54**	
Community-Based Day Services (Hour)	Hour	194	239.48	19.85	**922213.53**	
Therapeutic/Activity-Based Day Services (Month)	Month	2	6.00	131.78	**1581.36**	
Therapeutic/Activity-Based Day Services (Hour)	Hour	2	37.35	44.85	**3350.30**	
Mobility Related Day Services	Hour	2	17.47	57.87	**2021.98**	
Crisis Intervention and Support Total:						**73919.52**
Crisis Intervention and Support	Day	6	68.16	180.75	**73919.52**	
Environmental Accessibility Adaptations Total:						**2304.24**
Environmental Accessibility Adaptations	Adaptation	1	0.72	3200.33	**2304.24**	
Family Support Services Total:						**67522.85**
Family Support Services	Hour	24	305.81	9.20	**67522.85**	
Family/Consumer Training Total:						**215.52**
Family/Consumer Training	Hour	2	2.00	53.88	**215.52**	

GRAND TOTAL:	**10136417.03**
Total Estimated Unduplicated Participants:	**1000**
Factor D (Divide total by number of participants):	**10136.42**
Average Length of Stay on the Waiver:	6

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Access Supports Total:						**2724.25**
Housing Access Supports	Month	1	5.00	544.85	**2724.25**	
Individual Training and Education Total:						**21066.90**
Individual Training and Education	Hour	17	28.28	43.82	**21066.90**	
Massage Therapy Total:						**31020.00**
Massage Therapy	Hour	47	11.00	60.00	**31020.00**	
Non-Medical Transportation Total:						**648052.45**
Individual Transportation Providers	Miles	26	1526.15	0.55	**21823.94**	
Transportation Companies	Day	336	88.58	19.50	**580376.16**	
Public/Transit/Rental/Taxi	Month	77	5.50	108.27	**45852.34**	
Nutritional Consultation Total:						**77.34**
Nutritional Consultation	Hour	1	1.67	46.31	**77.34**	
Participant-Directed Goods and Services Total:						**6000.00**
Participant-Directed Goods and Services	Month	40	1.50	100.00	**6000.00**	
Personal Emergency Response Systems (PERS) Total:						**535.46**
Personal Emergency Response Systems (PERS)	Month	11	1.40	34.77	**535.46**	
Skilled Nursing Total:						**22534.31**
Skilled Nursing	Hour	6	60.92	61.65	**22534.31**	
Specialized Medical Equipment and Supplies Total:						**4480.77**
Specialized Medical Equipment and Supplies	Piece	5	2.28	393.05	**4480.77**	
Technology Total:						**60000.00**
Technology	Item	100	0.50	1200.00	**60000.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**19719.00**
Training and Counseling Services for Unpaid Caregivers	Hour	300	1.50	43.82	**19719.00**	

GRAND TOTAL:	**10136417.03**
Total Estimated Unduplicated Participants:	**1000**
Factor D (Divide total by number of participants):	**10136.42**
Average Length of Stay on the Waiver:	6

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition/Set Up Expenses: Other Service Total:						**1553.23**
Transition/Set Up Expenses: Other Service	Transition	2	0.50	1553.23	**1553.23**	
Vehicle Modifications and Adaptations Total:						**12100.00**
Vehicle Modifications and Adaptations	Modification	2	1.21	5000.00	**12100.00**	
				GRAND TOTAL:		**10136417.03**
				Total Estimated Unduplicated Participants:		**1000**
				Factor D (Divide total by number of participants):		**10136.42**
				Average Length of Stay on the Waiver:		6

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

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
Community Living Supports Total:						**8193139.43**
Licensed/Certified Residential Services	Month	78	7.70	3252.82	**1953643.69**	
Supported Living Services	Hour	213	1110.44	26.38	**6239495.73**	
Employment Supports Total:						**62973.91**
Supported Employment	Hour	23	74.87	36.57	**62973.91**	
Homemaker Total:						**72495.31**
Homemaker	Hour	19	210.92	18.09	**72495.31**	
Live-In Caregiver Total:						**2188725.00**
Live-In Caregiver	Month	375	7.70	758.00	**2188725.00**	
Prevocational Supports Total:						**935641.94**
Prevocational Supports	Day	174	150.75	35.67	**935641.94**	
Respite Services Total:						
				GRAND TOTAL:		**35460376.54**
				Total Estimated Unduplicated Participants:		**2500**
				Factor D (Divide total by number of participants):		**14184.15**
				Average Length of Stay on the Waiver:		8

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						2527158.65
In Home Respite Care	Hour	963	138.78	18.64	**2491145.41**	
Out-of-Home Respite Care	Day	12	41.19	72.86	**36013.24**	
Acupuncture Services Total:						**23023.00**
Acupuncture Services	Hour	23	15.40	65.00	**23023.00**	
Chiropractic Service Total:						**5215.98**
Chiropractic Service	Hour	5	15.40	67.74	**5215.98**	
Dental Services Total:						**20507.58**
Dental Services	Visit	45	1.20	379.77	**20507.58**	
Home Health Aide Total:						**153161.44**
Home Health Aide	Hour	18	450.21	18.90	**153161.44**	
Lenses and Frames Total:						**1066.08**
Lenses and Frames	Piece	2	6.37	83.68	**1066.08**	
Occupational Therapy Total:						**3623.28**
Occupational Therapy	Hour	3	24.80	48.70	**3623.28**	
Optometric/Optician Services Total:						**391.72**
Optometric/Optician Services	Hour	5	0.80	97.93	**391.72**	
Physical Therapy Total:						**3623.28**
Physical Therapy	Hour	3	24.80	48.70	**3623.28**	
Psychology Services Total:						**2574.26**
Psychology Services	Hour	5	12.32	41.79	**2574.26**	
Speech, Hearing and Language Services Total:						**1818.30**
Speech, Hearing and Language Services	Hour	2	16.53	55.00	**1818.30**	
Financial Management Service Total:						**914567.50**
Financial Management Service	Month	2500	7.70	47.51	**914567.50**	

GRAND TOTAL:	**35460376.54**
Total Estimated Unduplicated Participants:	**2500**
Factor D (Divide total by number of participants):	**14184.15**
Average Length of Stay on the Waiver:	8

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Facilitator Total:						**2532320.00**
Independent Facilitator	Hour	1750	11.20	129.20	**2532320.00**	
Behavioral Intervention Services Total:						**1019053.30**
Behavioral Intervention Services	Hour	212	83.86	57.32	**1019053.30**	
Communication Support Total:						**17912.97**
Communication Support	Hour	31	13.46	42.93	**17912.97**	
Community Integration Supports Total:						**13395548.31**
Community-Based Day Services (Day)	Day	1101	130.09	70.82	**10143484.15**	
Community-Based Day Services (Hour)	Hour	485	335.27	19.85	**3227728.11**	
Therapeutic/Activity-Based Day Services (Month)	Month	5	8.40	131.78	**5534.76**	
Therapeutic/Activity-Based Day Services (Hour)	Hour	5	52.28	44.85	**11723.79**	
Mobility Related Day Services	Hour	5	24.46	57.87	**7077.50**	
Crisis Intervention and Support Total:						**241460.31**
Crisis Intervention and Support	Day	14	95.42	180.75	**241460.31**	
Environmental Accessibility Adaptations Total:						**6464.67**
Environmental Accessibility Adaptations	Adaptation	2	1.01	3200.33	**6464.67**	
Family Support Services Total:						**236327.76**
Family Support Services	Hour	60	428.13	9.20	**236327.76**	
Family/Consumer Training Total:						**754.32**
Family/Consumer Training	Hour	5	2.80	53.88	**754.32**	
Housing Access Supports Total:						**0.00**
Housing Access Supports	Month	0	7.00	544.85	**0.00**	
Individual Training and Education Total:						**72863.02**
Individual Training and Education	Hour	42	39.59	43.82	**72863.02**	
Massage Therapy Total:						

GRAND TOTAL:	**35460376.54**
Total Estimated Unduplicated Participants:	**2500**
Factor D (Divide total by number of participants):	**14184.15**
Average Length of Stay on the Waiver:	8

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						109032.00
Massage Therapy	Hour	118	15.40	60.00	**109032.00**	
Non-Medical Transportation Total:						**2268567.30**
Individual Transportation Providers	Miles	65	2136.60	0.55	**76383.45**	
Transportation Companies	Day	840	124.01	19.50	**2031283.80**	
Public/Transit/Rental/Taxi	Month	193	7.70	108.27	**160900.05**	
Nutritional Consultation Total:						**325.10**
Nutritional Consultation	Hour	3	2.34	46.31	**325.10**	
Participant-Directed Goods and Services Total:						**21000.00**
Participant-Directed Goods and Services	Month	100	2.10	100.00	**21000.00**	
Personal Emergency Response Systems (PERS) Total:						**1908.18**
Personal Emergency Response Systems (PERS)	Month	28	1.96	34.77	**1908.18**	
Skilled Nursing Total:						**84130.06**
Skilled Nursing	Hour	16	85.29	61.65	**84130.06**	
Specialized Medical Equipment and Supplies Total:						**16299.78**
Specialized Medical Equipment and Supplies	Piece	13	3.19	393.05	**16299.78**	
Technology Total:						**210000.00**
Technology	Item	250	0.70	1200.00	**210000.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**69016.50**
Training and Counseling Services for Unpaid Caregivers	Hour	750	2.10	43.82	**69016.50**	
Transition/Set Up Expenses: Other Service Total:						**5436.31**
Transition/Set Up Expenses: Other Service	Transition	5	0.70	1553.23	**5436.30**	
Vehicle Modifications and Adaptations Total:						**42250.00**
Vehicle Modifications and Adaptations	Modification				**42250.00**	

GRAND TOTAL:	**35460376.54**
Total Estimated Unduplicated Participants:	**2500**
Factor D (Divide total by number of participants):	**14184.15**
Average Length of Stay on the Waiver:	8

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		5	1.69	5000.00		
				GRAND TOTAL:		35460376.54
				Total Estimated Unduplicated Participants:		2500
				Factor D (Divide total by number of participants):		14184.15
				Average Length of Stay on the Waiver:		8

Appendix J: Cost Neutrality Demonstration

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

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
Community Living Supports Total:						**11704468.84**
Licensed/Certified Residential Services	Month	78	11.00	3252.82	**2790919.56**	
Supported Living Services	Hour	213	1586.34	26.38	**8913549.28**	
Employment Supports Total:						**89965.13**
Supported Employment	Hour	23	106.96	36.57	**89965.13**	
Homemaker Total:						**103563.26**
Homemaker	Hour	19	301.31	18.09	**103563.26**	
Live-In Caregiver Total:						**3126750.00**
Live-In Caregiver	Month	375	11.00	758.00	**3126750.00**	
Prevocational Supports Total:						**1336649.07**
Prevocational Supports	Day	174	215.36	35.67	**1336649.07**	
Respite Services Total:						**3610275.43**
In Home Respite Care	Hour	963	198.26	18.64	**3558830.44**	
Out-of-Home Respite Care	Day	12	58.84	72.86	**51444.99**	
Acupuncture Services Total:						
				GRAND TOTAL:		50657826.63
				Total Estimated Unduplicated Participants:		2500
				Factor D (Divide total by number of participants):		20263.13
				Average Length of Stay on the Waiver:		11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						32890.00
Acupuncture Services	Hour	23	22.00	65.00	**32890.00**	
Chiropractic Service Total:						**7451.40**
Chiropractic Service	Hour	5	22.00	67.74	**7451.40**	
Dental Services Total:						**29394.20**
Dental Services	Visit	45	1.72	379.77	**29394.20**	
Home Health Aide Total:						**218803.03**
Home Health Aide	Hour	18	643.16	18.90	**218803.03**	
Lenses and Frames Total:						**1522.98**
Lenses and Frames	Piece	2	9.10	83.68	**1522.98**	
Occupational Therapy Total:						**5176.32**
Occupational Therapy	Hour	3	35.43	48.70	**5176.32**	
Optometric/Optician Services Total:						**558.20**
Optometric/Optician Services	Hour	5	1.14	97.93	**558.20**	
Physical Therapy Total:						**5176.32**
Physical Therapy	Hour	3	35.43	48.70	**5176.32**	
Psychology Services Total:						**3677.52**
Psychology Services	Hour	5	17.60	41.79	**3677.52**	
Speech, Hearing and Language Services Total:						**2597.10**
Speech, Hearing and Language Services	Hour	2	23.61	55.00	**2597.10**	
Financial Management Service Total:						**1306525.00**
Financial Management Service	Month	2500	11.00	47.51	**1306525.00**	
Independent Facilitator Total:						**3617600.00**
Independent Facilitator	Hour	1750	16.00	129.20	**3617600.00**	
Behavioral Intervention Services Total:						**1455790.43**

GRAND TOTAL:	**50657826.63**
Total Estimated Unduplicated Participants:	**2500**
Factor D (Divide total by number of participants):	**20263.13**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services	Hour	212	119.80	57.32	1455790.43	
Communication Support Total:						25591.86
Communication Support	Hour	31	19.23	42.93	25591.86	
Community Integration Supports Total:						19136302.45
Community-Based Day Services (Day)	Day	1101	185.84	70.82	14490468.87	
Community-Based Day Services (Hour)	Hour	485	478.96	19.85	4611067.66	
Therapeutic/Activity-Based Day Services (Month)	Month	5	12.00	131.78	7906.80	
Therapeutic/Activity-Based Day Services (Hour)	Hour	5	74.69	44.85	16749.23	
Mobility Related Day Services	Hour	5	34.94	57.87	10109.89	
Crisis Intervention and Support Total:						344957.76
Crisis Intervention and Support	Day	14	136.32	180.75	344957.76	
Environmental Accessibility Adaptations Total:						9216.95
Environmental Accessibility Adaptations	Adaptation	2	1.44	3200.33	9216.95	
Family Support Services Total:						337608.72
Family Support Services	Hour	60	611.61	9.20	337608.72	
Family/Consumer Training Total:						1077.60
Family/Consumer Training	Hour	5	4.00	53.88	1077.60	
Housing Access Supports Total:						0.00
Housing Access Supports	Month	0	10.00	544.85	0.00	
Individual Training and Education Total:						104095.29
Individual Training and Education	Hour	42	56.56	43.82	104095.29	
Massage Therapy Total:						155760.00
Massage Therapy	Hour	118	22.00	60.00	155760.00	
Non-Medical Transportation Total:						3240857.38
Individual Transportation Providers	Miles				109119.37	

GRAND TOTAL:	50657826.63
Total Estimated Unduplicated Participants:	2500
Factor D (Divide total by number of participants):	20263.13
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		65	3052.29	0.55		
Transportation Companies	Day	840	177.16	19.50	**2901880.80**	
Public/Transit/Rental/Taxi	Month	193	11.00	108.27	**229857.21**	
Nutritional Consultation Total:						**464.03**
Nutritional Consultation	Hour	3	3.34	46.31	**464.03**	
Participant-Directed Goods and Services Total:						**30000.00**
Participant-Directed Goods and Services	Month	100	3.00	100.00	**30000.00**	
Personal Emergency Response Systems (PERS) Total:						**2716.23**
Personal Emergency Response Systems (PERS)	Month	28	2.79	34.77	**2716.23**	
Skilled Nursing Total:						**120182.98**
Skilled Nursing	Hour	16	121.84	61.65	**120182.98**	
Specialized Medical Equipment and Supplies Total:						**23300.00**
Specialized Medical Equipment and Supplies	Piece	13	4.56	393.05	**23300.00**	
Technology Total:						**300000.00**
Technology	Item	250	1.00	1200.00	**300000.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**98595.00**
Training and Counseling Services for Unpaid Caregivers	Hour	750	3.00	43.82	**98595.00**	
Transition/Set Up Expenses: Other Service Total:						**7766.15**
Transition/Set Up Expenses: Other Service	Transition	5	1.00	1553.23	**7766.15**	
Vehicle Modifications and Adaptations Total:						**60500.00**
Vehicle Modifications and Adaptations	Modification	5	2.42	5000.00	**60500.00**	

GRAND TOTAL:	**50657826.63**
Total Estimated Unduplicated Participants:	**2500**
Factor D (Divide total by number of participants):	**20263.13**
Average Length of Stay on the Waiver:	11