

- 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 and continually meet all required standards prior to furnishing waiver services. Numerator = number of providers that initially and continually 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Regional Centers"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Department of Social Services (DSS)"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text" value="Department of Social Services (DSS)"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> DHCS, DSS and DDS meet quarterly to review issues concerning DSS licensed facilities </div>

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 that initially and continually meet all required standards prior to furnishing waiver services.

Numerator = number of non-licensed/non-certified providers that initially and continually meet all required standards prior to furnishing waiver services;

denominator = number of all non-licensed/non-certified 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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">Regional Centers</div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (check each that applies):</p>	<p>Frequency of data aggregation and analysis(check each that applies):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1227 1264 1308" type="text"/>
Other Specify: <input data-bbox="408 1451 647 1532" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1451 1264 1532" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1675 1264 1756" type="text"/>
	Other Specify: <input data-bbox="718 1899 954 1980" type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified during the States Biennial on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the States recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the States recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the States 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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="320 398 794 443" type="text" value="Regional Centers, DSS"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="866 640 1337 719" type="text"/>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

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

Furnish the information specified above.

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

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

As noted in state law (W&IC section 4684.80(a)) EBSHs provide services to a maximum of four individuals with private bedrooms and must conform with the HCBS settings requirements of 42 CFR 441.530(a)(1). Therefore, meeting the HCBS settings requirements is considered during the planning and development of these homes. EBSHs are designed for individuals who require more enhanced behavioral supports, staffing and supervision than is available in other licensed residential settings. In addition to the same licensing criteria for adult residential facilities and group homes, certification by DDS is also required as a condition of licensure of an EBSH. This certification requirement is another opportunity to review the planned service design for compliance with the HCBS settings requirements.

Community Crisis Homes (CCHs) – Similar to EBSHs, DDS certification is required as a condition of licensure. This certification requirement is an opportunity to review the planned service design for compliance with the HCBS settings requirements.

As these homes are new setting types under this waiver, each one will be assessed regarding compliance with the HCBS settings requirements prior to the submission of federal claiming for services provided in these settings. The assessment process will be as follows:

- The regional center, in conjunction with the consumers and service provider, will conduct an on-site assessment of the EBSH/CCHs using a standardized tool, developed as part of the State’s transition planning, which aligns with the HCBS settings requirements.
- This assessment will include a review of the EBSHs/CCHs 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 and provider
- The assessment will also indicate any setting requirements that initially were not met and the actions taken in response.
- Upon completion, the written assessment and supporting information will be forwarded to DDS for validation of the assessment findings via review of the supporting information and assessment. If validated, the individual EBSH/CCH is considered an eligible waiver provider.
- On-going monitoring of compliance with the HCBS settings requirements will occur in the following ways:
 - o During required on-site monitoring visits of all EBSHs/CCHs by DDS, and
 - o During the on-site 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.

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 individual 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 recipient 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 recipient/conservator, other individuals, may receive notice of the meeting and participate.

Appendix D: Participant-Centered Planning and Service Delivery

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 through a person-centered process of individualized needs determination with active participation by the individual/representative in the plan development and takes into account the individual's needs and preferences. Person-centered planning is an approach to determining, planning for, and working toward the preferred future of the individual and her or his family. In this approach to planning that is focused on the individual, other members of the planning team adopt the role of consultants or advisors who help the individual achieve their preferred future. Decisions regarding the goals, services and supports included in the IPP are driven by the individual. The IPP is prepared jointly by the planning team which at a minimum, consists of the HCBS Waiver recipient (consumer) 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 consumer/conservator, other individuals, including 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 (ex. the Client Development Evaluation Report or CDER) to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the consumer. 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, behavioral or safety risks that may require the development of mitigation strategies. Information is obtained from the consumer, 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 consumer and the family.

Utilizing information obtained during the assessment process, the IPP is prepared jointly by the planning team. 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. During the IPP meeting, consumers are informed of services available to them that could be options to meet their needs or choices. As changes arise, consumers are given information regarding services available to meet the change in need or choice. The IPP must also include a schedule of all services purchased by the regional center or obtained from generic resources. The receipt of these services is coordinated during the planning process to ensure any needed services available through generic resources are provided prior to accessing available waiver services.

The IPP must be reviewed (at least annually) and modified by the planning team when necessary. 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. Annually, and as changes arise, consumers are given information regarding services available to meet that change in need or choice. This allows the consumer and the planning team to choose services and supports to meet the changing need or choice. 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. Further information on monitoring the implementation of the service plan is contained in Appendix D-2(a).

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.

As noted above, 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 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.

For consumers that are supported in their own residence, services are available to assist in responding to emergencies or other unusual situations. Available services include 24-hour emergency assistance, such as direct service in response to calls for assistance. Additionally, support to become aware of and effectively use the police, fire, and emergency help available in the community is available. Services may also include assisting and facilitating the consumer's efforts to acquire, use, and maintain devices needed to summon immediate assistance when threats to health, safety, and well-being occur. The IPP planning team makes decisions regarding which, if any, of these services will be included in the IPP based on the consumer's needs and preferences.

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.

The case manager informs the consumer and/or his or her legal representative of qualified providers of services determined necessary through the IPP planning process. Consumers may meet with qualified providers prior to the final decision regarding providers to be identified in the service plan. The consumer's choice of providers includes consideration of, among other things, the provider's ability to deliver quality services or supports that can accomplish all or part of the person's program plan and the provider's success in achieving the objectives set forth in the consumer'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 State's Biennial on-site HCBS Waiver Monitoring Reviews, DHCS in conjunction with DDS reviews a random, representative sample of consumer IPPs to ensure all service plan requirements have been met.

As described in appendix A.6 of this application, the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews consist of a variety of activities that include verification of a statistically valid random sample of consumer IPPs. Please refer to Appendix A-6 for more detail.

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 Centers

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, including those consumers with changing needs. At least annually (or as needed), all IPPs are reviewed to determine that planned services have been provided, that sufficient progress has been made on the consumers' goals and objectives, that consumers and families are satisfied with the individual program plan and its implementation to assess the consumer's health, safety, well-being, and the effectiveness of services. For those consumers that reside in out-of-home settings (e.g. residential community care facilities, adult family homes, supported or independent living settings), this review of the IPP is completed during quarterly, face-to-face visits.

Further, as part of the State's Biennial on-site HCBS Waiver Monitoring Reviews, DHCS in conjunction with DDS reviews a random, representative sample of consumer IPPs to ensure IPP implementation monitoring is being completed. Service providers that furnish services to all consumers, including those with changing needs, are required to report special incidents to the regional center within 24 hours. In turn, the regional center is obligated to submit SIRs to DDS within two working days of as mandated by Title 17 54327.1. Regional centers are responsible for evaluating, tracking and providing remediation to maintain the health and safety of all consumers. If the State's on-site review identifies an unaddressed issue or non-remediation of an issue, it would result in a recommendation made to the regional center towards compliance in this area. DDS and DHCS request a regional center response within 30 days of receipt of the recommendation.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

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 Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<p>Representative Sample Confidence Interval =</p> <div data-bbox="1078 461 1262 741" style="border: 1px solid black; padding: 5px;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
<p>Other Specify:</p> <div data-bbox="408 882 644 958" style="border: 1px solid black; height: 34px; width: 148px;"></div>	Annually	<p>Stratified Describe Group:</p> <div data-bbox="1078 882 1262 1335" style="border: 1px solid black; padding: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	<p>Other Specify:</p> <div data-bbox="1078 1473 1262 1550" style="border: 1px solid black; height: 34px; width: 115px;"></div>
	<p>Other Specify:</p> <div data-bbox="719 1697 951 2011" style="border: 1px solid black; padding: 5px;"> On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed. </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 Biennial on-site HCBS Waiver Monitoring Reviews

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

		3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed. </div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 Biennial on-site HCBS Waiver Monitoring Reviews

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

		3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed. </div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of consumers/parents who are satisfied with the services received. Numerator = number of positive responses. Denominator = total number of interviews conducted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Interviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

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

		3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed. </div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

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

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

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

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

Performance Measure:

Number and percent of consumer IPPs that were revised, when needed, to address changing needs. Numerator = number of consumer IPPs that were revised to address change in consumer needs. Denominator = number of consumer records reviewed

that indicated a revision to the IPP was necessary to address changing needs.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</p> </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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 Biennial on-site HCBS Waiver Monitoring

Reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify:	

	<p>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</p>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 consumer IPPs reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</p> </div>	

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
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <p>Biennially</p> </div>

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 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 Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group:

		<p>The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.</p>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px;"> <p>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</p> </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group:

		<p>The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.</p>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px;"> <p>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</p> </div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (check each that applies):</p>	<p>Frequency of data aggregation and analysis (check each that applies):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified during the State’s Biennial on-site HCBS 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.

Remediation plans for individual issues typically involve technical corrections to the IPP (e.g. obtaining a consumer signature or clarification of wording to reflect the agreed upon services that are being provided.) When indicated, a planning team meeting (at minimum includes the consumer and regional center representative) is held to discuss and obtain agreement on necessary modifications to the IPP.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>

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.

In support of personal control over supports and services, self-direction is an option that enables participants to procure their own services. Self-direction of services empowers participants and families by giving them direct control over how and when the services are provided. Families and consumers will have the freedom to directly control and decision making authority over how and when the services are provided as an alternative to receiving services provided by staff hired by an authorized agency through the regional center.

For those participants who receive respite, family support services, skilled nursing, non-medical transportation, and/or community-based training services identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. As required by Title 17, CCR section 58886, when the decision to self-direct services is made, the regional center is required to provide the consumer/family member with information regarding their responsibilities and functions as either an employer or co-employer. For those selecting to self-direct the indicated services, a Financial Management Service (FMS) provider, vendored by the regional center, will perform selected administrative functions such as payroll, taxes, unemployment insurance, etc. This relieves the participant of the burden of these administrative functions while still having the freedom exercise decision making authority over the provision of services.

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 are available to participants who live in their own private residence, the home of a family member, or in a community living arrangement as defined in Appendix C.

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.

During the IPP planning team meeting, the regional center case manager is responsible for informing the waiver participant of their choice of agency providers or to self-direct for respite, family support services, non-medical transportation, community-based training services and/or skilled nursing services. The case manager will provide participants with information and requirements of this choice as required by Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer or co-employer, requirements regarding the use of a financial management service, etc.) This information is provided so the participant can make an informed decision about choosing agency or self-directed method of service delivery.

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:

Consumers (or their authorized, legal representative) have the opportunity to choose who may assist them in self-directing respite, family support services, non-medical transportation, community-based training service and/or skilled nursing services; however, the same requirements as specified in Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer or co-employer, requirements regarding the use of a financial management service, etc.) apply. Further, all FMS providers must be vendorized by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326 (e.g. submission of required applicant identifying information, records maintenance requirements, etc.); and, regional centers will ensure that FMS providers and providers of all self-directed services meet applicable laws ongoing and thereafter through oversight and monitoring activities.

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
Family Support Services		
Community-Based Training Service		
Skilled Nursing		
Respite Care		
Financial Management Service		
Non-Medical Transportation		

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 adult consumer or family member utilizing participant-directed services can act as a common law employer or a co-employer.

An FMS is an entity that functions as the adult consumers agent or family members agent in performing selected duties as follows:

- o Fiscal Employer/Agent: An FE/A ensures that Federal, state and local employment taxes and labor and workers compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner and that services are paid for appropriately and in a timely manner;
- o Co-employer: When the individual is a co-employer, the FMS ensures that the necessary employer-related duties and tasks, including payroll, are carried out.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers are paid a flat rate set by the State.

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:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
 Maintain all source documentation related to the authorized service(s) and expenditures.
 Maintain a separate accounting for each participants participant-directed funds.

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

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 of 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 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:

As noted in appendix E-1(e), regional center case managers are responsible for informing the waiver participant of their choice of agency providers or to self-direct for respite, family support services, non-medical transportation, community-based training service and/or skilled nursing services. The case manager will provide participants with information and requirements of this choice as required by Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer or co-employer, requirements regarding the use of a financial management service (FMS), etc.)

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
Home Health Aide	
Optometric/Optician Services	
Homemaker	
Communication Aides	
Speech, Hearing and Language Services	
Specialized Medical Equipment and Supplies	
Vehicle Modifications and Adaptations	
Prevocational Services	
Family Support Services	
Community-Based Training Service	
Physical Therapy	
Dental Services	
Personal Emergency Response Systems (PERS)	
Skilled Nursing	
Environmental Accessibility Adaptations	
Day Service	
Occupational Therapy	
Chore Services	
Family/Consumer Training	
Prescription Lenses and Frames	
Respite Care	
Transition/Set Up Expenses	
Supported Employment Individual	
Behavioral Intervention Services	
Community Based Adult Services	
Financial Management Service	
Psychology Services	
Non-Medical Transportation	
Housing Access Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Nutritional Consultation	
Community Living Arrangement Services	

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:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

i. 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:

Participants are able to switch to non-participant directed services at any time. A planning team meeting is held to update the IPP, and the case manager facilitates the transition and assures no break in service.

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.

Participant direction of services may be involuntarily terminated when the regional center determines the individual’s health and safety is not being supported or when the delivery of services cannot be verified. When there is a disagreement with a change in service delivery, the individual is provided with a Notice of Proposed Action and notified of their Fair Hearing rights. Regardless of the reason for termination of participant-direction, a planning team meeting is held to update the individual program plan and facilitate the transition from participant-direction to prevent a break in service.

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	8000	
Year 2	8309	
Year 3	8618	
Year 4	8927	
Year 5	9236	

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 (a.k.a agency with choice) entities function as legal employers in collaboration with family members or adult consumers, acting Co-Employers. As required by CCR, Title 17 §58884, the family member or adult consumer, acting as the Co-Employer, makes recommendations to the Financial Management Services Co-Employer on who to hire to provide Participant-Directed Services. The FMS Co-Employer must possess the ability to collect and process employee time records, assist family members or adult consumers, acting 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.

FMS Fiscal Employer/Agent (F/EA) entities function in collaboration with adult consumers or family members who choose to maintain their status as common law employers. For the purposes of processing payroll, the FMS F/EA must have the ability to process the worker pay, withholdings, filings and any required payments of applicable federal, state and local employment related taxes and insurance, and apply for and obtain authorization under Section 3504 of the Internal Revenue Code to be an agent for each consumer or family member represented. The FMS F/EA must be able to assist with the verification worker eligibility, collect and process employee time records, 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 prepare and distribute monthly expenditure reports to the Employer and the regional center. The FMS may process reimbursements but must do so according to IRS regulations. The FMS F/EA must be able to ensure payments do not exceed the amounts and rates authorized.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

No variation from Appendix C-2-a.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the state's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the

premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As required by the State Medicaid Manual (SMM) §2900.1, DD waiver recipients 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 recipient in a notice whenever any of the events described previously occur. Participants have access to fair hearing brochures, notification of resolution, and fair hearing request forms through their 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 recipient or authorized representative requests a fair hearing, a number of options are available to resolve the disagreement. The recipient or authorized representative may request a voluntary, informal meeting with the regional center, or mediation. Consistent with SMM §2902.1 and Welfare and Institutions Code (WIC) §4710.5(a), these steps are optional and do not take the place of the State level fair hearing. The recipient or authorized representative 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 recipient 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 recipient or authorized representative 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.) Pursuant to WIC §4712.7, and consistent with SMM §2903.5, the Director of DHCS, the State Medicaid Agency, has delegated the authority to adopt final decisions to the Director of OAH. Fair hearing decisions and files are maintained at the Office of Administrative Hearings. DDS is copied on all final documentation.

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:

DDS

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 against a regional center or service provider. The Consumer Complaint Process is the procedure to use if you believe that the regional center or a provider has violated or improperly withheld a right to which you are entitled under the law. Under this process, you are asking that the regional center or provider change its procedures for dealing with you and others in the future.

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 authorized representative. If the participant or authorized representative is not satisfied with the proposed resolution, the participant or authorized 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 (SIR) requirements and define the incident types that require a SIR, including:

- 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 consumer 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.

Qualified providers that furnish services to all regional center consumers, regardless if the consumer is on the waiver, 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 and then must provide a final report to DDS within 30 days.

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 States risk mitigation and management system for persons with developmental disabilities, of which training and education is a component.

Both DDS and the States 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 adequately 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.

Information is provided to caregivers and participants through a variety of mediums and frequencies:

- Safetynet Newsletter: Produced quarterly and includes training materials and information on topics relevant to the health, safety, and wellbeing of those served by DDS. Topics on protections from abuse, neglect, and exploitation are addressed annually at a minimum.
- Safetynet Email Blasts: Monthly emails with articles and information regarding the health, safety, and wellbeing of those served by DDS go out to all subscribers, including clients, caregivers, providers, and regional centers.
- Social Media Posts: Posts about protections from issues including abuse, neglect, and exploitation are posted multiples times per day on Facebook and twitter.
- Regional Center Websites: Regional centers have links on their websites to articles and newsletters created by Safetynet.

The States 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 review 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 have been completed.

- 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 States Risk Mitigation and Management System for all individuals with developmental disabilities, including those that are Waiver participants. DDS carries out this responsibility on an ongoing basis by:

1. Developing, implementing and maintaining a uniform, statewide automated SIR database system.
2. Reviewing individual SIRs daily to identify issues or concerns requiring additional follow-up.
3. Revising regulations, as needed, related to SIR requirements to address system requirements.
4. Providing SIR data (such as risk indicators, client characteristics, corrective actions, etc.) to the States independent risk management contractor for further analyses and to regional centers for follow-up, as appropriate.
5. 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.
6. Developing and maintaining a statewide mortality review system that includes development and maintenance of a statewide database of all persons who have died, and conducting studies to educate and inform the service system so as to improve quality of life outcomes for participants.
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.

DHCS is the single state agency for the DD Waiver. DDS is the operating agency for the DD Waiver. DHCS and DDS exercise oversight of the waiver through the Biennial On-Site HCBS Waiver Monitoring reviews at the 21 regional centers. Several components of the review address risk management activities, including SIRs.

1. DHCS and DDS review compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity through the review of DD Waiver participant records at the regional center and at day and living service providers for the review sample.
2. Additionally, DHCS and DDS review compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity for 10 SIRs for DD Waiver participants who are not in the sample.

DHCS performs additional focused on site reviews of SIRs when it is deemed necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The 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 seclusion or 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. 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 the regional center and subsequently 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 DD 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 restraints and 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 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:

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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 DD 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).

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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:

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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:

First-line monitoring for medication regimens is the responsibility of the consumer's prescribing physician (ongoing).

Second-line monitoring is conducted in the following ways:

- The Person-centered planning team, which includes a regional center representative, through their monitoring of the IPP (as needed, and annually at a minimum) includes a review of the consumer's health status.
- Regional centers' monitor provider compliance with assisting consumers to receive medical care and medication management follow-up pursuant to the IPP (as needed, and quarterly at a minimum.)
- Community Care Licensing monitoring (annually)
- DDS and DHCS monitoring review (biannually)

All regional centers have personnel with clinical expertise who routinely provide training and/or information to individuals who conduct second-line monitoring to help recognize situations that present a potential risk to the consumer. In these situations, regional center clinical personnel are available to consult with the consumer's prescribing physician as necessary.

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 detailed in appendix H, which include (but are not limited to), the States overall risk mitigation and management system and the Biennial on-site HCBS Waiver Monitoring Review. The States risk management contractor reviews electronic special incident report data for trends in medication errors and unplanned hospitalizations due to medication errors. 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 (DSS), a review of medication policies/procedures is conducted. DSS 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).

Assistance with self-administration of medication may be performed by trained, non-medical personnel. The State requires mandatory direct support professional training, which includes medication management, handling, and assistance with self-administration of medication. Additionally, the licensee must receive training from a licensed professional, obtain written documentation from the licensed professional, and ensure that the licensed professional reviews staff performance as the licensed professional deems necessary, at least once a year. Once ordered by the physician, the medication is given according to the physician's directions. Pursuant to 22 CCR § 80075, the following regulations shall apply to the oversight of assistance with self-administration: A record of each dose is maintained in the client's record. The record shall include the date and time the PRN medication was taken, the dosage taken, and the client's response. If the client is unable to determine his/her own need for a prescription or nonprescription PRN medication, and is unable to communicate his/her symptoms clearly, facility staff designated by the licensee, shall be permitted to assist the client with self-administration, provided all of the following requirements are met:

- Facility staff shall contact the client's physician prior to each dose, describe the client's symptoms, and receive direction to assist the client in self-administration of that dose of medication.
- The date and time of each contact with the physician, and the physician's directions, shall be documented and maintained in the client's facility record.
- The date and time the PRN medication was taken, the dosage taken, and the client's response, shall be documented and maintained in the client's facility record.
- For every prescription and nonprescription PRN medication for which the licensee provides assistance, there shall be a signed, dated written order from a physician on a prescription blank, maintained in the client's file, and a label on the medication.

- 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 providers care are required to be reported to (1) the regional center and (2) the appropriate 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 providers 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 providers 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.

Please see Appendix G-3- b-i & G-3-b-ii.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of 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 within 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	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Regional centers"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text" value="Daily"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews conducted during States Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

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

		<p>Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px;"> <p>3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level</p> </div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; padding: 5px;"> <p>The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.</p> </div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px;"> <p>In addition to reviewing any special incidents for consumers included in the random sample, a supplemental sample is reviewed of ten consumers with a reported special incident at each regional center.</p> </div>
	<p>Other Specify:</p>	

	On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Regional centers Independent risk management contractor </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Number and percent of providers that maintain a safe environment and safeguard medications. Numerator = number of providers that maintain a safe environment and safeguard medications; denominator = total number of providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Site reviews conducted during State’s Biennial on-site HCBS Waiver Monitoring Reviews

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

<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; width: 150px; height: 30px; margin: 5px 0;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 120px; height: 30px; margin: 5px 0;"></div>
	Other Specify:	

	On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Regional Centers"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text" value="Daily"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews conducted during State’s Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

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

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Regional centers Independent risk management contractor </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify:

		<p>In addition to reviewing any special incidents for consumers included in the random sample, a supplemental sample is reviewed of ten consumers with a reported special incident at each regional center.</p>
	<p>Other Specify:</p> <p>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</p>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<p>Other Specify:</p> <p>Regional centers</p> <p>Independent risk management contractor</p>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input style="width: 100%; height: 20px;" type="text"/>

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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
Other Specify:	Annually	Stratified Describe Group:

<div style="border: 1px solid black; padding: 2px; display: inline-block;">Regional Centers</div>		<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">Regional centers, independent risk management contractor</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin: 0 auto;"></div>

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 needs 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):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group:

		<p>The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.</p>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px;"> <p>On-site reviews are conducted at each regional center (RC) every two years. Focused follow -up reviews are conducted annually or more frequently as needed.</p> </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

Regional centers have the primary responsibility for ensuring appropriate steps are taken in response to special incidents. These steps may include; identifying the factors that led to the incident, ensuring service providers responded appropriately, assessing the need for provider training and determining if modifications to the consumers IPP are needed. The actions taken are documented in the incident report or consumer record.

Daily, DDS staff review submitted special incident and, when necessary, follow-up with the regional center

Individual issues identified during the States Biennial on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the States recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the States recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the States recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

ii. **Remediation Data Aggregation**

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Regional centers Independent risk management contractor </div>	Annually

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

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 Biennial on-site HCBS 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).

As noted previously in this application, in California, all community-based services for individuals with developmental disabilities are provided through a statewide system of 21 regional centers, who are funded by the Department of Developmental Services (DDS). Within this structure, and under the oversight of the Department of Health Care Services (DHCS), DDS ensures that the HCBS Waiver is implemented in accordance with Medicaid law and the State's approved Waiver application. It is through this same service delivery system that California also provides services under the 1915(i) State Plan Amendment (SPA), 16-016/16-047. As a result, the overall QIS described in this appendix applies to services provided under both programs. However, for federal reporting, California will collect and report information specific to each program for the performance measures under the following federal assurances:

- Administrative Authority – All performance measures with the exception of joint meetings and participation in the Quality Management Executive Committee (discussed later in this appendix.)
- Level of Care – Only applies to the HCBS Waiver
- Service Plans
- Health and Welfare
- Financial Accountability

Additionally, California will report consolidated data for performance measures under the following assurances:

- Administrative Authority – Joint oversight meetings between DHCS and DDS will address operation of both the HCBS Waiver and 1915(i) SPA. Additionally, Quality Management Executive Committee meetings review all aspects of the service delivery system. Therefore, separate meetings specific to each program are not held.
- Qualified Providers - Service delivery and provider requirements are the same under both the HCBS Waiver and the 1915(i) SPA. As a result, participants of both programs receive services concurrently from the same providers. Therefore, performance measure data related to this assurance will be the same for both the HCBS Waiver and 1915(i) SPA.

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 a mortality system improvement initiative to enhance and improve the

information reported on mortality, 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; 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.

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.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <input type="text"/>	Other Specify: <input type="text" value="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 HCBS 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 HCBS Waiver personnel (i.e. qualified intellectual disabilities professionals). Participation in these committees affords DDS and regional center stakeholders regular opportunities to review and communicate about system performance and HCBS Waiver related policies. DDS’ regular participation in these committees is a mechanism through which technical assistance 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.

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

No

Yes (*Complete item H.2b*)

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

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

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. The DDS audit is designed to "wrap around" the required independent audit to ensure comprehensive financial accountability. DDS reviews each regional center's 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 and regional centers also conduct audits of service providers. Upon the issuance of the Final Audit report, all consumer billings identified for reimbursement by the vendor are remitted to the Home and Community Based Waiver by the DDS Waiver Section. This is done prior to the outcome of any vendor appeal or administrative hearing. If the findings of the audit are non-monetary, the vendoring regional center(s) are responsible for ensuring future vendor compliance with the DDS audit recommendation(s). If the audit findings are monetary, the vendor is required to reimburse the DDS directly. Once the vendor has agreed to pay the DDS Accounting Section tracks and monitors the vendor's payment(s). If the vendor refuses to pay, the DDS Accounting follows collection procedures.

Specified providers pursuant to State law must obtain an independent audit or review of their financial statements annually. A specified provider is an entity that receives payments between \$500,000 and \$2,000,000 from one or more regional centers and must obtain an independent review report of its financial statements. Providers who receive more than \$2,000,000 in regional center payments must obtain an independent audit. The results of these audits or reviews 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. A periodic independent audit of the waiver program is required by the Single Audit Act and conducted by the California state auditor.

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 participates in vendor audit entrance/exit conferences as appropriate.
4. DHCS A&I reviews draft DDS vendor audit reports and audit working papers.
5. DHCS submits annual report of DHCS A&I's oversight activities to CMS.

In the DDS draft regional center audit reports, DHCS A&I looks for any potential problems or special issues. The following are examples of material

findings based on past audit reports where vendors were referred to DOJ:

- Lack of documentation/support for significant percentage/amount of the cost claimed by the regional center and/or vendor. A general rule is more than 30% of their costs.
- Timesheets appeared to have altered or overstated hours, appeared excessive (vendor claiming services provided by individuals which exceed 8 hours per day)
- Individual's hours are being billed directly and also included on vendor's timesheets
- Regional Center/Vendor does not have payroll records to evidence individuals providing services were paid.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of claims paid in accordance with the consumers authorized services. Numerator = number of claims paid in accordance with the consumers authorized services; denominator = total number of claims for participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews conducted during States Biennial on-site HCBS 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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>3.01 Based on sample size of 1050, population of 130,000 and 95% confidence level</p> </div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<i>Annually</i>	<p>Stratified Describe Group:</p>

		<p><i>The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.</i></p>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px;"> <p><i>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</i></p> </div>	

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
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

Performance Measure:

Number and percent of claims paid in accordance with the reimbursement methodology in the approved waiver only for services rendered. Numerator = number of claims paid in accordance with the reimbursement methodology in the approved waiver only for services rendered; denominator = total number of claims reviewed only for the services rendered.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Vendor audits conducted by regional centers

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 = <input type="text"/>
Other Specify: <input type="text" value="Regional centers"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<p><i>Each regional center must conduct a fiscal audit no less than 4% of the total number of vendors in specified service categories for which payments in the prior year totaled \$100,000 or less.</i></p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<i>Annually</i>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<i>Continuously and</i>	<i>Other</i>

	Ongoing	<p><i>Specify:</i></p> <div style="border: 1px solid black; padding: 5px; margin: 5px;"> <p><i>DDS fiscal vendor audits are conducted based on a random sample of vendors with annual expenditures over \$100,000 or upon referral.</i></p> </div>
	<p>Other <i>Specify:</i></p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDS Biennial Regional Center audits

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<p>Other <i>Specify:</i></p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	<p>Stratified <i>Describe Group:</i></p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other <i>Specify:</i>

		<p>5-10% of the most heavily utilized services are sampled to verify accuracy of billing. Lesser utilized services are also sampled for review at a rate of less than 5%.</p>
	<p>Other Specify:</p> <p>Fiscal audits are conducted at each regional center every two years. Follow-up fiscal audits are conducted annually or more frequently as needed.</p>	

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
<p>Other Specify:</p> <div data-bbox="405 1597 799 1682" style="border: 1px solid black; height: 38px; width: 247px;"></div>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <div data-bbox="868 1883 1262 1968" style="border: 1px solid black; height: 38px; width: 247px;"></div>

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 States Biennial on-site HCBS 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 = <div style="border: 1px solid black; padding: 5px;"> 3.01 Based on sample size of 1050, population of 130,000, and 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px 0;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px;"> The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC. </div>
	Continuously and Ongoing	Other Specify:

	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p><i>On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.</i></p> </div>	

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="5-10% of the most heavily utilized services are sampled to verify accuracy of billing. Lesser utilized services are also sampled for review at a rate of less than 5%."/> 5-10% of the most heavily utilized services are sampled to verify accuracy of billing. Lesser utilized services are also sampled for review at a rate of less than 5%.
	Other Specify:	

	<p><i>Fiscal audits are conducted at each regional center every two years. Follow-up fiscal audits are conducted annually or more frequently as needed.</i></p>	
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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: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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).

The rate methodologies for services provided in this waiver are as follows:

Behavior Intervention Service

This service is comprised of the following subcategories:

A. Non-Facility-Based Behavior Intervention Services– Providers in this subcategory are Behavior Analyst, Associate Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, Psychiatrist, Psychiatric Technician, Crisis Team, Client/Parent Support, Parent Support Services, Individual/Family Training Providers, Family Counselor, Behavior Intervention Training and Behavioral Technician. There are two rate setting methodologies for all providers in this subcategory (except psychiatrists – see below.) If the provider does not have a “usual and customary” rate as described below, then the rate is established using the median rate setting methodology.

1) The usual and customary rate methodology – Per California Code of Regulations (CCR), Title 17, Section 57210(a)(19), a usual and customary rate “means the rate which is regularly charged by a vendor for a service that is used by both regional center consumers and/or their families and where at least 30% of the recipients of the given service are not regional center consumers or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a regional center consumer and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual with a developmental disability who is not a regional center consumer, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act.” DDS does not establish or review usual and customary rates, as these rates are for services accessed by the general public.

2) The median rate setting methodology – This methodology applies if the usual and customary rate methodology is not applicable to the provider. The Department calculates median rates for each regional center, and these rates are subsequently certified by each of the regional centers. The Department calculates the statewide median rates based on the individual regional center median rates. Verification of individual regional center median rates is subject to verification through the department’s biennial fiscal audit of the regional center. Rates for new providers where rates are set through negotiation with regional centers are capped at either the statewide median rate or the vendoring regional center’s median rate, whichever is lower unless a regional center demonstrates an increase to the fixed new vendor rate is necessary for a provider to provide the service in order to protect a beneficiary’s health and safety needs. As required by the contract between regional centers and the State, regional centers must maintain documentation on the process to determine, and the rationale for granting, any negotiated rate, including consideration of the type of service and any education, experience and/or professional qualifications required for the service. In addition, contracts or agreements between the regional center and service providers shall expressly require that no more than 15 percent of regional center funds be spent on administrative expenditures.

This methodology requires that rates negotiated with new providers may not exceed the regional center’s current median rate for the same service, or the statewide current median rate, whichever is lower.

Effective July 1, 2016, these median rates were increased for the purpose of enhancing wages and benefits for provider staff who spend 75 percent of their time providing direct services for consumers as well as administrative expenses for service providers. Chapter 28, Statutes of 2019 (SB 81, Committee on Budget and Fiscal Review), provided the Department of Developmental Services (DDS) with time-limited funding to provide rate increases for specified services effective January 1, 2020 through December 31, 2021. The rate increases shall be suspended at the end of this period unless certain conditions, specified in SB 81, apply. Information about those conditions can be found in the bill language in the following link: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB81 Under section 4691.12(a)(2). The following chart with percentage increases for specified services receiving an increase can be found here: https://www.dds.ca.gov/VendorInfo/docs/Supplemental_Rate_Increases.pdf

These rates were set and reviewed in 2019

3) Schedule of Maximum Allowances - The rates for psychiatrists are determined by the “Schedule of Maximum Allowances (SMA).” State regulations define the SMA as the current rate established by the single-state Medicaid agency for services reimbursable under the Medi-Cal program. The SMA is the maximum amount that can be paid for the service. These rates can be found here: http://files.medi-cal.ca.gov/pubsdoco/rates/rates_download.asp For providers who have a usual and customary rate that is less than the SMA, the regional center shall pay the provider’s usual and customary rate.

SMA rates are set by DHCS. The Medi-Cal Fee Schedule containing the SMAs are updated on the 15th day of every month. Most adjustments to rates are tied to the annual Healthcare Common Procedure Coding System (HCPCS) process (which may adjust codes/rates across multiple services and provider types), or other state/federal authorized/mandated adjustments. DHCS develops a policy justification for rate changes, outlines authorities relevant and needed to adjust the rates, and works with the Fiscal Intermediary (FI) to update rates. DHCS reviews SMA rates on a monthly basis assuring payments are consistent with efficiency, economy, and quality of care. DHCS updates the fee schedule accordingly.

B. Crisis Support – The following two rate methodologies apply for these providers;

1) The usual and customary rate methodology – As defined previously or, if the provider does not have a usual and customary rate;

2) The median rate setting methodology - As defined previously.

3) Community Crisis Homes (CCHs) rate methodology – As described in California Welfare and Institutions Code section 4698 and California Code of Regulations, Title 17, section 59022, there are three components to the monthly rate for Community Crisis Homes:

1) the facility component: the allowable costs used to calculate the facility component include payroll costs of facility staff and facility related costs such as lease, facility maintenance, repairs, cable/internet, etc. The facility rate is set upon approval of cost information submitted by the vendor to the regional center. Rates are reviewed as part of the contract renewal between the vendor and the regional center, pursuant to 17 CCR 59014.

2) the individualized services and supports component: the allowable costs used to calculate the individualized services and supports component include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports and other consumer specific program costs. These rates are set upon approval of cost information submitted by the vendor to the regional center. The rate is reviewed within 30 days of initial placement and at least every six months thereafter.

3) and the transition plan component: the allowable costs used to calculate the transition component includes the salaries, wages, payroll taxes and benefits of direct care staff providing additional services and supports needed to support a consumer during times of transition out of the CCH. These rates are set upon approval of cost information submitted by the vendor to the regional center. The rate is reviewed at least monthly.

As part of the certification process for CCHs, the Department reviews the proposed facility component rate and supporting documentation for each CCH to determine if the included costs are reasonable and economical. These rates must be approved by the Department prior to the delivery of service at each CCH. Note: This is not the rate that is claimed for FFP. See Appendix I-5 for a description of the method used to isolate and exclude room and board costs from the rate for purposes of Medicaid payment.

CONTINUATION OF I-2(a) RATE DETERMINATION METHODS CAN BE FOUND UNDER MAIN(B) OPTIONAL.

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 providers, referred to as regional center vendors. 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.) The Regional Centers then bill DDS, which operates the Waiver program under an interagency agreement and fiscal agent contract with the Department of Health Services, the Medicaid agency. Providers are not required to contract and/or bill via the regional centers. Please refer to appendix A.6 of this waiver for information regarding Program Policy Compliance.

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 only on the total costs of services provided. By using the methods described in items I-2-d and I-3-a, DDS ensures that only those costs that 1) are provided to eligible individuals, and 2) are 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:

Claims are processed and validated at all levels through automated processes. Only claims for services for which a purchase authorization, based on decisions made in development of the individual service plan (IPP), is in place are able to be processed for provider payment by the regional center.

Regional centers transmit all expenditures (claims) to DDS through a system of main frame computers. At DDS the expenditures are processed through a specialized filter program 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.

As described in appendix A.6 of this application, the States Biennial on-site HCBS Waiver Monitoring Reviews also include verification that a statistically valid random sample of consumer IPPs identify all services purchased by regional centers. Further, each year all consumers are provided a complete listing of all the services funded (and paid for) on their behalf, pursuant to their IPP. This listing includes the service type, units, and month of service and the amount paid. The state law requiring the provision of an annual statement was implemented for the purpose of assuring that the services and supports paid for, were delivered to the recipient.

- 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, purchase authorization number, consumer identification and eligibility information, service code, service rate, claim amount, and claim date. Waiver services will not be paid unless the appropriate authorization and billing data are present. Regional centers transmit to DDS all service authorization and billing data necessary to support the provider claims to provide a complete audit trail. Regional centers 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 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. HCBS 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. Regional centers were created as a result of Legislation passed in 1969 which mandated that a network of regional centers be created in California. Each regional center provides services to individuals with developmental disabilities in their "catchment area." DDS contracts with each regional center's governing board for a term of five years. The contract includes required program and fiscal provisions.

(b)The DDS OHCDS is an open network. Regional centers evaluate and approve prospective providers through a process referred to as vendorization. The purpose of vendorization is to ensure that the provider meets DDS and HCBS 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 providers reimbursed for DDS services.

(c) Consumers select their providers through the development and implementation of an individual program plan (IPP). A consumer is not limited to providers already vendored by the regional center. If a consumer selects another provider, that provider is then vendored to ensure that it meets provider qualifications and is enrolled in the regional centers payment system.

(d) DDS establishes the qualifications for providers. The regional centers, as agents of DDS, are responsible for ensuring that 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 providers (through the vendor process) and require providers to meet all applicable Medicaid requirements (e.g., the maintenance of necessary documentation).

(f) The regional centers pay enrolled 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. Providers are not required to contract and/or bill via the regional center.

iii. Contracts with MCOs, PIHPs or PAHPs.

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

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

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

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

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

not selected

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

Appendix I: Financial Accountability

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

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

Appropriation of State Tax Revenues to the State Medicaid agency

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

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

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:

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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:

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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:

--

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services	Visit	172	2.17	37.15		
Physical Therapy Total:						133920.00
Physical Therapy	Hour	558	4.00	60.00	133920.00	
Prescription Lenses and Frames Total:						37488.69
Prescription Lenses and Frames	Piece	387	1.00	96.87	37488.69	
Psychology Services Total:						706854.87
Psychology Services	Hour	905	18.69	41.79	706854.87	
Speech, Hearing and Language Services Total:						135090.02
Speech, Hearing and Language Services	Hour	934	2.55	56.72	135090.02	
Financial Management Service Total:						6379888.35
Financial Management Service	Month	9889	11.00	58.65	6379888.35	
Chore Services Total:						3620.00
Chore Services	Hour	4	36.20	25.00	3620.00	
Communication Aides Total:						2382682.06
Communication Aides	Hour	2866	23.19	35.85	2382682.06	
Community Based Adult Services Total:						11646858.40
Community Based Adult Services	Daily	1043	146.41	76.27	11646858.40	
Community-Based Training Service Total:						10813.55
Community-Based Training Service	Hour	4	166.67	16.22	10813.55	
Environmental Accessibility Adaptations Total:						1168112.50
Environmental Accessibility Adaptations	Adaptation	239	1.15	4250.00	1168112.50	
Family Support Services Total:						21600119.92
Family Support Services	Hour	3456	583.57	10.71	21600119.92	
Family/ Consumer Training Total:						154743.36
Family/ Consumer					154743.36	
GRAND TOTAL:						4089432386.68
Total Estimated Unduplicated Participants:						140000
Factor D (Divide total by number of participants):						29210.23
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training	Hour	718	4.00	53.88		
Housing Access Services Total:						52650.00
Housing Access Services	Hour	81	10.00	65.00	52650.00	
Non-Medical Transportation Total:						255752620.47
Transportation Companies	Daily	62083	156.27	24.33	236042614.28	
Individual Transportation Providers	Miles	4639	2989.12	0.60	8319916.61	
Public Transit/Rental/Taxi	Month	13311	11.00	77.79	11390089.59	
Nutritional Consultation Total:						63116.32
Nutritional Consultation	Hour	569	2.61	42.50	63116.32	
Personal Emergency Response Systems (PERS) Total:						1102873.42
Personal Emergency Response Systems (PERS)	Month	3142	11.00	31.91	1102873.42	
Skilled Nursing Total:						11086480.95
Registered Nurse (RN)	Hour	2810	10.52	60.86	1799094.63	
Licensed Vocational Nurse (LVN)	Hour	597	424.70	36.63	9287386.32	
Specialized Medical Equipment and Supplies Total:						3186528.00
Specialized Medical Equipment and Supplies	Piece	1747	1.52	1200.00	3186528.00	
Transition/Set Up Expenses Total:						3875.00
Transition/Set Up Expenses	Transition	1	1.00	3875.00	3875.00	
Vehicle Modifications and Adaptations Total:						2683200.00
Vehicle Modifications and Adaptations	Modification	258	2.08	5000.00	2683200.00	
GRAND TOTAL:						4089432386.68
Total Estimated Unduplicated Participants:						140000
Factor D (Divide total by number of participants):						29210.23
Average Length of Stay on the Waiver:						340

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						284047805.03
Behavior Intervention Services	Hour	35355	127.81	57.03	257702747.03	
Crisis Support	Daily	117	119.80	862.00	12082309.20	
Community Crisis Homes - Facility Costs	Month	40	8.80	11075.24	3898484.48	
Community Crisis Homes - Individual Costs	Month	40	8.80	29380.78	10342034.56	
Community Crisis Homes - Transition Costs	Daily	24	7.00	132.32	22229.76	
Community Living Arrangement Services Total:						1987711260.58
Supported Living Services	Hour	11322	1803.06	28.05	572619581.23	
Licensed/Certified Residential Services	Month	33289	11.00	3849.01	1409426632.79	
In-Home Day Program	Daily	337	216.32	77.71	5665046.57	
Day Service Total:						1197341215.17
Community-based Day Services	Daily	63669	206.45	69.15	908939758.21	
Community-based Day Services	Hour	27251	500.04	20.99	286022124.94	
Therapeutic/Activity-Based Day Services	Month	145	11.00	50.00	79750.00	
Therapeutic/Activity-Based Day Services	Hour	560	80.08	43.88	1967789.82	
Mobility-Related Day Services	Hour	125	68.27	38.88	331792.20	
Homemaker Total:						16765308.41
Homemaker	Hour	2576	360.17	18.07	16765308.41	
Prevocational Services Total:						93756118.87
Prevocational Services	Daily	10768	226.92	38.37	93756118.87	
GRAND TOTAL:						4239564539.76
Total Estimated Unduplicated Participants:						145000
Factor D (Divide total by number of participants):						29238.38
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:						268850218.77
In-Home Respite Care	Hour	56428	207.40	22.00	257469678.40	
Out-of-Home Respite Care	Daily	3604	37.89	83.34	11380540.37	
Supported Employment Individual Total:						7162590.03
Incentive Payments - 30 days	One-time	125	1.00	1000.00	125000.00	
Incentive Payments - 6 months	One-time	113	1.00	1250.00	141250.00	
Incentive Payments - 12 months	One-time	94	1.00	1500.00	141000.00	
Supported Employment Individual	Hour	1339	128.21	39.35	6755340.03	
Dental Services Total:						4711920.00
Dental Services	Visit	10155	1.45	320.00	4711920.00	
Home Health Aide Total:						49391379.07
Home Health Aide	Hour	2688	648.14	28.35	49391379.07	
Occupational Therapy Total:						138600.00
Occupational Therapy	Hour	462	5.00	60.00	138600.00	
Optometric/Optician Services Total:						14349.56
Optometric/Optician Services	Visit	178	2.17	37.15	14349.56	
Physical Therapy Total:						138720.00
Physical Therapy	Hour	578	4.00	60.00	138720.00	
Prescription Lenses and Frames Total:						38844.87
Prescription Lenses and Frames	Piece	401	1.00	96.87	38844.87	
Psychology Services Total:						731848.63
Psychology Services	Hour	937	18.69	41.79	731848.63	
Speech, Hearing and Language Services Total:						139863.01
Speech, Hearing and Language Services	Hour	967	2.55	56.72	139863.01	
GRAND TOTAL:						4239564539.76
Total Estimated Unduplicated Participants:						145000
Factor D (Divide total by number of participants):						29238.38
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Service Total:						6607626.30
Financial Management Service	Month	10242	11.00	58.65	6607626.30	
Chore Services Total:						3620.00
Chore Services	Hour	4	36.20	25.00	3620.00	
Communication Aides Total:						2466792.65
Communication Aides	Hour	2968	23.19	35.84	2466792.65	
Community Based Adult Services Total:						12060025.96
Community Based Adult Services	Daily	1080	146.41	76.27	12060025.96	
Community-Based Training Service Total:						10813.55
Community-Based Training Service	Hour	4	166.67	16.22	10813.55	
Environmental Accessibility Adaptations Total:						1212100.00
Environmental Accessibility Adaptations	Adaptation	248	1.15	4250.00	1212100.00	
Family Support Services Total:						22375124.23
Family Support Services	Hour	3580	583.57	10.71	22375124.23	
Family/ Consumer Training Total:						160346.88
Family/ Consumer Training	Hour	744	4.00	53.88	160346.88	
Housing Access Services Total:						54600.00
Housing Access Services	Hour	84	10.00	65.00	54600.00	
Non-Medical Transportation Total:						264885932.43
Transportation Companies	Daily	64300	156.27	24.33	244471757.13	
Individual Transportation Providers	Miles	4805	2989.12	0.60	8617632.96	
Public Transit/Rental/Taxi	Month	13786	11.00	77.79	11796542.34	
Nutritional Consultation Total:						65334.82
Nutritional Consultation	Hour	589	2.61	42.50	65334.82	
GRAND TOTAL:						4239564539.76
Total Estimated Unduplicated Participants:						145000
Factor D (Divide total by number of participants):						29238.38
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						3412704.00
Specialized Medical Equipment and Supplies	Piece	1871	1.52	1200.00	3412704.00	
Transition/Set Up Expenses Total:						3875.00
Transition/Set Up Expenses	Transition	1	1.00	3875.00	3875.00	
Vehicle Modifications and Adaptations Total:						2870400.00
Vehicle Modifications and Adaptations	Modification	276	2.08	5000.00	2870400.00	
GRAND TOTAL:						4087466841.24
<i>Total Estimated Unduplicated Participants:</i>						150000
<i>Factor D (Divide total by number of participants):</i>						27249.78
<i>Average Length of Stay on the Waiver:</i>						340