State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 23, 2021

Mr. James G. Scott, Director
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
Division of Program Operations
601 East 12th Street, Suite 0300
Kansas City, MO 64106-2898

STATE PLAN AMENDMENT 21-0002: RENEWAL OF 1915i STATE PLAN FOR THE DEVELOPMENTALLY DISABLED

Dear Mr. Scott:

The California Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 21-0002 to the Centers for Medicare & Medicaid Services (CMS). SPA 21-0002 is submitting the Home and Community Based Services (HCBS) 1915i State Plan in its entirety for review to CMS.

This SPA proposes to renew the California Medicaid 1915(i) State Plan for the Developmentally Disabled for an additional five years, with a proposed effective date of October 1, 2021. The five-year period would be in effect from October 1, 2021, to September 30, 2026.

Pursuant to the Lanterman Developmental Disabilities Services Act (Lanterman Act), Welfare & Institutions (W&I) Code section 4500 et seq., people with developmental disabilities, as defined in W&I Code section 4512(a), receive, as an entitlement, services and supports based on their individual needs and choices. The Department of Developmental Services (DDS) is responsible for administering the Lanterman Act.

DHCS estimates that the expenditures for this renewal will be $411,762,000 in federal funds for federal fiscal year (FFY) 2021-22 and $432,350,000 in federal funds for FFY 2022-23.

All proposed SPAs are subject to approval by CMS.

Director's Office
1501 Capitol Avenue, MS 0000
P.O. Box 997413, Sacramento, CA 95899-7413
Phone (916) 440-7400, Fax (916) 440-7404
Internet Address: http://www.DHCS.ca.gov

If you have any questions please contact Mr. Richard Nelson, Chief, Integrated Systems of Care Division, at (916) 345-7957, or by Richard.Nelson@dhcs,ca,gov.

Sincerely,

[redacted]

Jacey Cooper
State Medicaid Director
Chief Deputy Director
Health Care Programs

Enclosures

cc: Ms. Autumn Boylan
Assistant Deputy Director
Health Care Delivery Systems
Department of Health Care Services
Autumn.Boylan@dhcs.ca.gov

Mr. Richard Nelson, Chief
Integrated Systems of Care Division
Department of Health Care Services
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Ms. Maricris Acon
Deputy Director
Federal Programs Division
Department of Developmental Services
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0002

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 1915i of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 2021-22 $ 411,762,000
b. FFY 2022-23 $ 432,350,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i pages 1-149
Attachment 4.19-B pages 1-19
Attachment 2.2-A pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i pages 1-149
Attachment 4.19-B pages 1-19
Attachment 2.2-A pages 1-2

10. SUBJECT OF AMENDMENT
1915i State Plan Renewal

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
Jacey Cooper
Digitally signed by Jacey Cooper
Date: 2021.03.23 07:41:40 -07'00'

13. TYPED NAME
Jacey Cooper

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
March 23, 2021

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS
For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

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

2. **Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

Select one:

◉	Not applicable
○	Applicable
	Check the applicable authority or authorities:
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:* *(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 specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program operated under §1932(a) of the Act. *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
☐	A program authorized under §1115 of the Act. *Specify the program*:			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
○	The Medical Assistance Unit *(name of unit)*:	
○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
◉	The State plan HCBS benefit is operated by *(name of agency)*	
	The Department of Developmental Services	
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☒	☐	☒
2 Eligibility evaluation	☑	☒	☐	☒
3 Review of participant service plans	☑	☒	☐	☒
4 Prior authorization of State plan HCBS	☑	☒	☐	☒
5 Utilization management	☑	☒	☐	☒
6 Qualified provider enrollment	☑	☒	☐	☒
7 Execution of Medicaid provider agreement	☑	☒	☐	☒
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☒	☐	☒
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☒	☐	☒
10 Quality assurance and quality improvement activities	☑	☒	☐	☒

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

This 1915(i) SPA employs an Organized Health Care Delivery System (OHCDS) arrangement. The Department of Developmental Services (DDS) is the OHCDS.

DDS Meets the Regulatory Definition of an OHCDS. Federal Medicaid regulations define an OHCDS as "a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization." 42 C.F.R. § 447.10(b). The term OHCDS is "open to interpretations broad enough to apply to systems which are not prepaid organizations." See State Medicaid Directors dated December 23, 1993. An OHCDS "must provide at least one service directly (utilizing its own employees, rather than contractors)." *Id.* "So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish Medicaid covered services." *Id.*

There are adequate safeguards to ensure that OHCDS subcontractors possess the required qualifications and meet applicable Medicaid requirements e.g. maintenance of necessary documentation for the services furnished. Under state law, regional centers are responsible for ensuring that providers meet these qualifications.

The OHCDS arrangements preserve participant free choice of qualified providers. Free choice of qualified providers is a hallmark of the California system. Recipients of 1915(i) services select their providers through the person centered planning process orchestrated by the regional centers, which culminates in the development of an individual program plan (signed by the beneficiary) delineating the services to be provided and the individual's choice of provider of such service(s). If an individual's choice of provider is not vendorized, they must go through the regional center vendorization process to ensure that they meet all necessary qualifications. The vendorization process is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services. The vendorization process allows regional centers to verify, prior to the provision of services to individuals, that a provider applicant meets all of the requirements and standards specified in regulations. If a provider meets the qualifications, the regional center must accept them as a vendored provider in the OHCDS.

1915(i) providers are not required to contract with an OHCDS in order to furnish services to participants. Although the open nature of the OHCDS means that virtually all providers will be part of the OHCDS, in the event a provider does not want to affiliate with the OHCDS and regional center, they may go directly to the Department of Health Care Services to execute a provider agreement. However, under state law, the process for qualifying a vendor to provide home-and-community based services to an individual with developmental disabilities is through the regional center.

The OHCDS arrangement provides for appropriate financial accountability safeguards.

Qualified providers of 1915(i) SPA services submit claims to the regional center for services delivered to the beneficiary, pursuant to the individual program plan. The regional center reviews the claim (units of service, rate, etc), pays legitimate claims, and submits the claim of payment to DDS as the OHCDS. The OHCDS reimburses the regional center for the actual cost of the service, certifies the expenditures and submits a claim for the federal financial participation to the Department of Health Care Services. DDS does not "add on" to the actual costs of services incurred by and reimbursed to the regional centers.

The costs for administrative activities are not billed as part of the OHCDS payment and are claimed separately at the appropriate administrative rate.

(By checking the following boxes the State assures that):

5. ☒ Conflict of Interest Standards. The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

N/A

6. ☒ Fair Hearings and Appeals. The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ No FFP for Room and Board. The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒ Non-duplication of services. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2021	9/30/2022	60,000
Year 2	10/1/2022	9/30/2023	63,000
Year 3	10/1/2023	9/30/2024	66,000
Year 4	10/1/2024	9/30/2025	69,000
Year 5	10/1/2025	9/30/2026	72,000

2. ☒ Annual Reporting. *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ Medicaid Eligible. *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. Medically Needy (*Select one*):

○ The State does not provide State plan HCBS to the medically needy.

● The State provides State plan HCBS to the medically needy. (*Select one*):

○ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

● The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
◉	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Regional Centers

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The minimum requirement for conducting evaluations/reevaluations 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.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process for evaluating/reevaluating eligibility for State plan HCBS involves a review of current pertinent information in the individual's record, such as medical, social and psychological evaluations, the individual program plan, progress reports, case management notes and other assessment information. The review verifies the determination the individual meets the needs-based eligibility criteria including the existence of significant functional limitations in three or more areas of major life activity including; receptive/expressive language, learning, self-care, mobility, self-direction, capacity for independent living and economic self-sufficiency.

4. ☒ Reevaluation Schedule. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ Needs-based HCBS Eligibility Criteria. *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The individual has a need for assistance demonstrated by:

- A need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 et seq.), to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands; and
- A likelihood of retaining new skills acquired through habilitation over time; and
- A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential, that continues, or can be expected to continue, indefinitely; and
- The existence of significant functional limitations in at least three of the following areas of major life activity, as appropriate to the person's age:
    - Receptive and expressive language;
    - Learning;
    - Self-care;
    - Mobility;
    - Self-direction;
    - Capacity for independent living.

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The individual meets the following criteria: 1. A need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 *et seq.*), to teach or	Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's order. The need must	The individual must be diagnosed with a developmental disability and a qualifying developmental deficit exists in either the self-help or social-emotional area.	The individual requires: • Continuous availability of facilities, services, equipment and medical and nursing personnel for prevention, diagnosis or

train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands (as opposed to rehabilitation services to restore functional skills); and 2. A likelihood of retaining new skills acquired through habilitation over time; and 3. A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential, that continues, or can be expected to continue, indefinitely; and 4. The existence of significant functional limitations in at least three of the	be for a level of service which includes the continuous availability of procedures such as, but not limited to, the following: • Nursing assessment of the individuals' condition and skilled intervention when indicated; • Administration of injections and intravenous of subcutaneous infusions; • Gastric tube or gastronomy feedings; • Nasopharyngeal aspiration; • Insertion or replacement of catheters • Application of dressings involving prescribed medications; • Treatment of extensive decubiti; • Administration of medical gases	For self-help, a qualifying developmental deficit is represented by two moderate or severe skill task impairments in eating, toileting, bladder control or dressing skill. For the social-emotional area, a qualifying developmental deficit is represented by two moderate or severe impairments from a combination of the following; social behavior, aggression, self-injurious behavior, smearing, destruction of property, running or wandering away, or emotional outbursts.	treatment of acute illness or injury.

following areas of major life activity, as appropriate to the person's age • Receptive and expressive language; • Learning; • Self-care; • Mobility; • Self-direction; • Capacity for independent living;			

*Long Term Care/Chronic Care Hospital
**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

In addition to the needs identified above, the individual must also have a diagnosis of a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code and Title 17, California Code of Regulations, §54000 and §54001 as follows:

Welfare and Institutions Code 4512. As used in this division:

(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

Title 17, CCR, §54000. Developmental Disability.

(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

Title 17, CCR, §54001. Substantial Disability.

(a)"Substantial disability" means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care:

(D) Mobility:

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	◉	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this 1915(i) HCBS SPA will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

As noted in state law, W&IC section 4684.80(a) for EBSHs and W&IC 4698(b)(l) for CCHs, EBSHs/CCHs 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)(l). 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/CCH. This certification requirement is another opportunity to review the planned service design for compliance with the HCBS settings requirements.

As these homes are new setting types under this 1915i, 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 1915i provider.
- On-going monitoring of compliance with the HCBS settings requirements will occur in the following ways:
- During required on-site monitoring visits of all EBSHs/CCHs by DDS, and
- During the on-site 1915i 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.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(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.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(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.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

   The service plan, commonly referred to as the individual program plan (IPP), is prepared jointly by the planning team, which at minimum includes the individual or, as appropriate their parents, legal guardian or conservator, or authorized representative and a representative from the regional center. When invited by the individual, others may join the planning team.

   The IPP is developed through a person-centered process of individualized needs determination with the opportunity for 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. Decisions regarding the individual's goals, services and supports included in the IPP are made by agreement of the planning team.

a) *the supports and information made available* –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.

For those participants who receive respite, 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 consumer/family member is provided with information regarding their responsibilities and functions as either an employer or co-employer as well the requirement to use and assistance in identifying a Financial Management Services provider.

b) The *participant's authority to determine who is included in the process* – As noted above, 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/parent/representative, other individuals, may receive notice of the meeting and participate.

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The case manager informs the recipient and/or his or her legal representative of qualified providers of services determined necessary through the IPP planning process. Recipients may meet with qualified providers prior to the final decision regarding providers to be identified in the service plan.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

On a biennial basis, DHCS in conjunction with DDS will review a representative sample of recipient IPPs to ensure all service plan requirements have been met.

9. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☒	Other (*specify):*	Regional centers are required to maintain service plans for a minimum of five years.			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Habilitation – Community Living Arrangement Services
Service Definition (Scope)*:*	

Habilitation—Community Living Arrangement Services (CLAS) includes two components, based on the setting:

A) Licensed/certified settings - CLAS provided in these settings include assistance with acquisition, retention, or improvement in skills related to living in the community. Services and supports include assistance with activities of daily living, (e.g. personal grooming and cleanliness, bed making and household chores, eating and the preparation of food), community inclusion, social and leisure skill development and the adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Services provided in licensed/certified settings will take into consideration the provision of the following:

1. Private or semi-private bedrooms shared by no more than two persons with personal décor. The choice of residential settings, including making decisions regarding sharing a bedroom, is made during the person-centered planning process.

2. Private or semi-private bathrooms. The residence must have enough bathroom space to ensure residents' privacy for personal hygiene, dressing, etc.

3. Common living areas or shared common space for interaction between residents, and residents and their guests.

4. Residents must have access to a kitchen area at all times.

5. Residents' opportunity to make decisions on their day-to-day activities, including visitors and when and what to eat, in their home and in the community.

6. Services which meet the needs of each resident.

7. Assurance of residents rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family; e) use the telephone with privacy; f) choose how and with whom to spend free time; and g) have opportunities to take part in community activities of their choice; h) residential units are accessible to the individual and have lockable entrance doors with appropriate staff having keys; i) entering into an admission agreement and taking occupancy affords residents of licensed residential facilities the same protections from eviction that tenants have under landlord tenant law of the State, county, city or other designated entity.

Residential settings that contain multiple independent living units (e.g. apartments) are considered home-like settings for the purposes of this State Plan Amendment.

B) Supported living services (provided in residences owned or leased by the recipients.) - CLAS provided in these settings are tailored supports that provide assistance with acquisition, retention, or improvement in skills related to:

- Activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of meals, including planning, shopping, cooking, and storage activities;
- Social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support;
- Locating and scheduling appropriate medical services;
- Managing personal financial affairs;
- Selecting and moving into a home;
- Locating and choosing suitable house mates;
- Acquiring household furnishings;
- Recruiting, training, and hiring personal attendants;
- Acquiring, using, and caring for canine and other animal companions specifically trained to provide assistance;
- Acquiring, using and maintaining devices to facilitate immediate assistance when threats to health, safety, and well-being occur.

CLAS may include additional activities, as appropriate, to meet the recipients' unique needs. These activities include those that address social, adaptive, behavioral, and health care needs as identified in the individual program plan. CLAS may also include the provision of medical and health care services that are integral to meeting the daily needs of residents (e.g., routine administration of medications or tending to the needs of residents who are ill or require attention to their medical needs on an ongoing basis). Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents are not included.

The specific services provided to each recipient vary based on the residential setting chosen and needs identified in the individual program plan.

Payments will not be made for the routine care and supervision which would be expected to be provided by a family, or for activities or supervision for which a payment is made by a source other than Medi-Cal. Payments for CLAS in licensed/certified settings do not include the cost for room and board. The method by which the costs of room and board are excluded from payment in these settings is specified in Attachment 4.19-B.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Foster Family Agency (FFA)-Certified Family Homes (Children Only)	FFA licensed pursuant to Health and Safety Code §§1500-1567.8 provides statutory authority for DSS licensing of facilities identified in the CA Community Care Facilities Act. As appropriate, a business license as required by the local jurisdiction where the	Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes.	Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA's, certification and use of homes, FFA administrator qualifications: (1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or, (2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position. Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).

	business is located.		
Foster Family Homes (FFHs) (Children Only) Payment for this service will not be duplicated or supplanted through Medicaid funding.	Health and Safety Code §§1500-1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR §§89200-89587.1 Regulations adopted by DSS to specify requirements for licensure of Foster Family Homes. Qualifications/Requirements for FFH providers: 1. Comply with applicable laws and regulations and: 2. Provide care and supervision to meet the child's needs including communicating with the child; 3. Maintain all child records, safeguard cash resources and personal property; 4. Direct the work of others in providing care when applicable, 5. Apply the reasonable and prudent parent standard; 6. Promote a normal, healthy, balanced, and supported childhood experience and treat a child as part of the family; 7. Attend training and professional development; 8. Criminal Records/Child Abuse Registry clearance; 9. Report special incidents; 10. Ensure each child's personal rights; and, 11. Maintain a clean, safe, health home environment. 12. Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.
Small Family Homes (Children Only)	Health and Safety Code §§1500-1567.8 As appropriate, a business license as required by the local jurisdiction where the	N/A	Title 22, CCR §§ 83000-83088. Regulations adopted by DSS to specify requirements for licensure of Small Family Homes. Licensee/Administrator Qualifications ▪ Criminal Records/Child Abuse Index Clearance; ▪ At least 18 years of age; ▪ Documented education, training, or experience in providing family home care and supervision appropriate to

	business is located.		the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours is not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted: o Child Development; o Recognizing and/or dealing with learning disabilities; o Infant care and stimulation; o Parenting skills; o Complexities, demands and special needs of children in placement; o Building self-esteem, for the licensee or the children; o First aid and/or CPR; o Bonding and/or safeguarding of children's property; o Ability to keep financial and other records; o Ability to recruit, employ, train, direct the work of and evaluate qualified staff. Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.
Group Homes (Children Only)	Health and Safety Code §§ 1500-1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR, § 84000-84808 Regulations adopted by DSS to specify requirements for licensure of Group Homes. Administrator Qualifications: 1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children; 2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above); 3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or

			4.Completed high school, or equivalent, plus at least three years administrative or supervisory experience (as above); and, 5. Criminal Records/Child Abuse Registry Clearance Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.
Adult Residential Facilities (ARF)	Health and Safety Code §§ 1500 through 1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception. Administrator Qualifications ▪ At least 21 years of age; ▪ High school graduation or a GED; ▪ Complete a program approved by DSS that consists of 35 hours of classroom instruction o 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities; o 3 hrs. in business operations; o 3 hrs. in management and supervision of staff; o 5 hrs. in the psychosocial needs of the facility residents; o 3 hrs. in the use of community and support services to meet the resident's needs; o 4 hrs. in the physical needs of the facility residents; o 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents; o 4 hrs. on admission, retention, and assessment procedures; ▪ Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%. ▪ Criminal Record/Child Abuse Registry Clearance. Additional Administrator Qualifications may also include:

			▪ Has at least one year of administrative and supervisory experience in a licensed residential program for persons ▪ with developmental disabilities, and is one or more of the following: (A) A licensed registered nurse. (B) A licensed nursing home administrator. (C) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities. (D) An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs. Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.
Residential Care Facility for the Elderly (RCFE)	Health and Safety Code §§1569-1569.889 provides statutory authority for licensing of RCFEs. Identified as the CA Residential Care Facilities for the Elderly Act. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR, §§87100-87793: Establish licensing requirements for facilities where 75 percent of the residents are sixty years of age or older. Younger residents must have needs compatible with other residents. Administrator Qualifications: 1. Knowledge of the requirements for providing care and supervision appropriate to the residents. 2. Knowledge of and ability to conform to the applicable laws, rules and regulations. 3. Ability to maintain or supervise the maintenance of financial and other records. 4. Ability to direct the work of others. 5. Good character and a continuing reputation of personal integrity. 6. High school diploma or equivalent. 7. At least 21 years of age. 8. Criminal Record Clearance. Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.

Residential Facility (out of state)	Appropriate Facility License, as required by State law. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Department approval is required per the Welfare and Institutions Code, § 4519. Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.
Adult Residential Facility for Persons with Special Health Care Needs	Health and Safety Code §§1500-1569.87 Appropriate license DSS CCLD as to type of facility As appropriate, a business license as required by the local jurisdiction where the business is located.		Welfare and Institutions Code, § 4684.50 et seq. The administrator must: 1. Complete the 35-houradministrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception, 2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following: a. A licensed registered nurse. b. A licensed nursing home administrator. c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities. d. An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

			Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.
Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	AFH Title 17, CCR, §56088 Authorizes the FHA to issue a Certificate of Approval to each family home which has: 1. Completed the criminal record review ; 2. Been visited by the FHA and a determination ensuring safe and reasonable and the prospective providers experience, knowledge, cooperation, history and interest to become an approved family home. 3. Completed required orientation and training.	Welfare and Institutions Code 4689.1-4689.6 provides statutory authority for FHA. FHA employs sufficient staff with the combined experience, training and education to perform the following duties: 1. Administration of the FHA; 2. Recruitment of family homes; 3. Training of FHA staff and family homes; 4. Ensuring an appropriate match between the needs and preferences of the consumer and the family home; 5. Monitoring of family homes; 6. Provision of services and supports to consumers and family homes which are consistent with the consumer's preferences and needs and the consumer's IPP; and 7. Coordination with the regional center and others. In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.
Supported Living Provider	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the	N/A	SLS requirements: 1. Service design including: ▪ Staff hiring criteria, including any minimum qualifications requirements; and ▪ Procedures and practices the agency will use to screen paid staff, consultants, and volunteers who will have direct contact with consumers. 2. Staff appropriate to services rendered with skills to establish and maintain

	business is located.		constructive and appropriate personal relationship with recipients, minimize risks of endangerment to health, safety, and well-being of recipients, perform CPR and operate 24-hour emergency response systems, achieve the intended results of services being performed and maintenance of current and valid licensure, certification, or registration as are legally required for the service. 3. Staff orientation and training in theory and practice of supported living services and recipient training in supported living services philosophy, recipient rights, abuse prevention and reporting, grievance procedures and strategies for building and maintaining a circle of support.
In-Home Day Program	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Qualifications and training for staff in agency guidelines. Must have a provision for an annual assessment process to ensure consumer participation in this type of program remains appropriate. Providers may include employees of community-based day, pre-vocation, or vocational programs.
Enhanced Behavioral Supports Homes (EBSH) (Agency)	Licensed Adult Residential Facility or group home by the Department of Social Services pursuant to Health and Safety Code §§ 1567.61 - 1567.80 As appropriate, a business license as required by the local jurisdiction where the business is located.	Certified by the Department of Developmental Services pursuant to WIC 4684.80	In addition to the requirements in Title 22, CCR, §§85000-85092, the following requirements from Title 17, CCR, §§59060-59061 also apply: Administrator Qualifications (a) An administrator must: (1) Have a minimum of 2 years of prior experience providing direct care or supervision to individuals with developmental disabilities; and be one of the following: (A) A registered behavior technician. (B) A licensed psychiatric technician. (C) A qualified behavior modification professional.

			(b) An administrator must complete the residential services orientation as required per Section 56003(b) Direct Care Staff Qualifications. (a) A direct care lead staff person must: (1) Have at least one year prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and (2) Become a registered behavior technician within 60 days of initial employment; or, be either: (A) A licensed psychiatric technician; or (B) A qualified behavior modification professional. (b) A direct care staff person must: (1) Have at least six months prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and (2) Become a registered behavior technician within twelve months of initial employment; or be: (A) Be a licensed psychiatric technician.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Habilitation Community Living Arrangement Services providers	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care Facilities	Department of Social Services – Community Care Licensing Division (DSSCCLD) regional centers – including verification of standards identified in "Needs-Based Evaluation/Reevaluation" item #8.	Annually Annually

Family Home Agency Adult Family Home and Family Teaching Home	regional centers DDS Family Home Agency	Annually Biennially Monthly

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Habilitation – Day Services**

Service Definition (Scope)*:*

Habilitation – Day Services includes three components:

A) Community-Based Day Services – (Providers identified with "CB" below)

These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which may take place in a residential or non-residential setting. Services may be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care. These services enable the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation service may serve to reinforce skills or lessons taught in school, therapy, or other settings. Day habilitation services may include paid/volunteer work strategies when the individualized planning process determines that supported employment or prevocational services are not appropriate for the individual.

B) Activity-Based/Therapeutic Day Services – (Providers identified with "AT" below)

These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills through therapeutic and/or physical activities and are designed to:

- Gain insight into problematic behavior
- Provide opportunities for expression of needs and feelings
- Enhance gross and fine motor development
- Promote language development and communication skills
- Increase socialization and community awareness
- Improve communication skills
- Provide visual, auditory and tactile awareness and perception experiences
- Assist in developing appropriate peer interactions

C) Mobility Related Day Services – (Providers identified with "MT" below)

These services foster the acquisition of greater independence and personal choice by teaching individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently.

The above described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17).

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits):*

A consumer may receive specialized recreation and non-medical therapies (including, but not limited to, art, dance, and music) when the regional center determines that the service is a primary or critical means for ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's need.

☒ Medically needy *(specify limits):*

A consumer may receive specialized recreation and non-medical therapies (including, but not limited to, art, dance, and music) when the regional center determines that the service is a primary or critical means for ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's need.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Mobility Training Services Agency (MT)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Personnel providing this service possess the skill, training or education necessary to teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently including: a) previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns; b) a valid California Driver's license and current insurance; c) ability to work independently with minimal supervision according to specific guidelines; and

			d) flexibility and adaptive skills to facilitate individual recipient needs.
Mobility Training Services Specialist (MT)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Individuals providing this service possess the following minimum requirements: 1. Previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns; 2. A valid California Driver's license and current insurance; 3. Ability to work independently, flexibility and adaptive skills to facilitate individual recipient needs.
Driver Trainer (MT)	Valid California driver's license As appropriate, a business license as required by the local jurisdiction where the business is located.	Current certification by the California Department of Motor Vehicles as a driver instructor.	N/A
Adaptive Skills Trainer (CB)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Individual providing this service shall possess: 1. Master's degree in education, psychology, counseling, nursing, social work, applied behavior analysis, behavioral medicine, speech and language or rehabilitation; and 2. At least one year of experience in the designing and implementation of adaptive skills training plans.
Personal Assistant (CB)	No state licensing category As appropriate, a business license as required by the	N/A	N/A

	local jurisdiction where the business is located.		
Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)	Facility license (Health and Safety Code §§ 1500-1567.8) if applicable As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Qualifications and training of staff per agency guidelines. For Community Integration Training Program: Program directors must have at least a bachelor's degree. Direct service workers may be qualified by experience.
Activity Center (CB)	Facility license (Health and Safety Code §§ 1500-1567.8) if applicable As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.
Adult Development Centers (CB)	Facility license (Health and Safety Code §§ 1500-1567.8) if applicable) As appropriate, a business license as required by the local jurisdiction where the	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.

	business is located.		
Behavior Management Program (CB)	Facility license (Health and Safety Code §§ 1500-1567.8) if applicable As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.
Independent Living Program (CB)	Facility license (Health and Safety Code §§ 1500-1567.8) if applicable As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.
Independent Living Specialist (CB)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Possesses the skill, training, or education necessary to teach recipients to live independently and/or to provide the supports necessary for the recipient to maintain a self-sustaining, independent living situation in the community, such as one year experience providing services to individuals in a residential or non-residential setting and possession of at least a two-year degree in a subject area related to skills training and development of program plans for eligible individuals.
Social Recreation Program (CB)	Facility license (Health and Safety Code §§	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc.

	1500-1567.8) if applicable As appropriate, a business license as required by the local jurisdiction where the business is located.		Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.
Art Therapist (AT)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	Current registration issued by the American Art Therapy Association.	N/A
Dance Therapist (AT)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	Validly registered as a dance therapist by the American Dance Therapy Association.	N/A
Music Therapist (AT)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the	Valid registration issued by the National Association for Music Therapy.	N/A

	business is located.		
Recreational Therapist (AT)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	Certification issued by either the National Council for Therapeutic Recreation Certification or the California Board of Recreation and Park Certification.	N/A
Specialized Recreational Therapy (AT)	Credentialed and/or licensed as required by the State in the field of therapy being offered As appropriate, a business license as required by the local jurisdiction where the business is located.	Equestrian therapists shall possess a current accreditation and instructor certification with the North American Riding for the Handicapped Association	N/A
Creative Art Program (AT)	Facility license (Health and Safety Code §§ 1500-1567.8) if applicable As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Program Director: Equivalent of a high school diploma and experience with persons with developmental disabilities. Direct Care Staff: Must have artistic experience as demonstrated through a resume.
Special Olympics Trainer (AT)	No state licensing category.	N/A	Knowledge and training sufficient to ensure consumer participation in Special Olympics.

	As appropriate, a business license as required by the local jurisdiction where the business is located.		
Sports Club: (e.g. YMCA, Community Parks and Recreation Program, Community-based recreation program) (AT)	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	All community recreational program providers shall possess the following minimum qualifications: 1. Ability to perform the functions required by the individual plan of care; 2. Demonstrated dependability and personal integrity; 3. Willingness to pursue training as necessary based upon the individual consumer's needs.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Habilitation – Day Services providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care Facilities	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers	Annually

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Habilitation - Behavioral Intervention Services**

Service Definition (Scope)*:*

Habilitation—Behavioral Intervention Services include two components:

A) Individual/Group Practitioners - May provide Behavioral Intervention Services in multiple settings, including the individual's home, workplace, depending on the individual's needs. These practitioners may also provide non-facility-based crisis services when needed. Use of state-operated mobile crisis services are available for individuals continuing to experience crises and have exhausted all other available crisis services. Crisis teams are unique in providing partnerships, assessments, training and support to individuals experiencing crisis and who are at risk of having to move from their own or family home, or from an out-of-home placement to a more restrictive setting. Mobile crisis teams' services are available for deployment 24-hours a day, 7 days a week after individualized assessments are completed. Participants have the choice of either a state-operated or vendor operated crisis team.

B) Crisis Support – If relocation becomes necessary, emergency housing in the person's home community is available. Crisis Support provides a safe, stable highly structured environment by combining concentrated, highly skilled staffing (e.g. psychiatric technicians, certified behavior analysts) and intensive behavior modification programs. Conditions that would qualify an individual for crisis support include aggression to others, self-injurious behavior, property destruction, or other pervasive behavior issues that have precluded effective treatment in the current living arrangement.

While the location and intensity of the components of this service vary based on the individual's needs, all components of behavioral intervention services include use and development of intensive behavioral intervention (see #1 below) programs to improve the recipient's development; and behavior tracking and analysis. The intervention programs will be restricted to generally accepted, evidence-based, positive approaches. Behavioral intervention services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Services may be provided to family members if they are for the benefit of the recipient. Services for family members may include training and instruction about treatment regimens and risk management strategies to enable the family to support the recipient.

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

(1) "Intensive behavioral intervention" means any form of applied behavioral analysis (ABA) based treatment (see #2 below) that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

(2) "Applied behavioral analysis based treatment" means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Behavioral Habilitation services do not include services otherwise available to the person under the Individuals with Disabilities Education Act or the Rehabilitation Act of 1973.

Behavioral Intervention services will supplement and not supplant Behavioral Health Treatment services available through EPSDT for individuals with a diagnosis of Autism Spectrum Disorder.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	Consumers are limited to no more than 12 months in a community crisis home in a service plan year and up to 18 consecutive months in total, per occurrence. Any additional day(s) must be approved by the Department and reviewed monthly thereafter. Should these limits be reached, the regional center and community crisis home will follow the transition plan developed for the consumer to identify an alternative residential setting with services and supports that meet the consumer's needs.
☒	Medically needy *(specify limits):*
	Consumers are limited to no more than 12 months in a community crisis home in a service plan year and up to 18 consecutive months in total, per occurrence. Any additional day(s) must be approved by the Department and reviewed monthly thereafter. Should these limits be reached, the regional center and community crisis home will follow the transition plan developed for the consumer to identify an alternative residential setting with services and supports that meet the consumer's needs.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Crisis Team-Evaluation and Behavioral Intervention	Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff assigned to the team.	Certified as appropriate to the skilled professions staff assigned to the team.	Program utilizes licensed and/or certified personnel as appropriate to provide develop and implement individualized crisis behavioral services plans. Specific qualifications and training of personnel per agency guidelines consistent with requirements for Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant: Psychologist, Psychiatric Technician or Psychiatrist established in this section.

	As appropriate, a business license as required by the local jurisdiction where the business is located.		
Crisis Intervention Facility	Health and Safety Code §§1500-1569.889 As appropriate, a business license as required by the local jurisdiction where the business is located.	Refer to "Other Standard."	Crisis services may be provided in any of the types of 24-hour care services identified in Habilitation – Community Living Arrangement Services (CLAS) section. Refer to the CLAS section for standards.
Psychiatrist	Business and Professions Code, Division 2, Chapter 5, commencing at § 2000 Licensed as a physician and surgeon by the Medical Board of California. As appropriate, a business license as required by the local jurisdiction where the business is located.	Certified by the American Board of Psychiatry and Neurology	N/A
Behavior Management Assistant:	As appropriate, a business license as	Registered as either:	Possesses a Bachelor of Arts or Science Degree and has either:

(Psychology Assistant; Associate Licensed Clinical Social Worker)	required by the local jurisdiction where the business is located. Business and Professions Code §2913; §4996-4996.2	1. A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or 2. An Associate Licensed Clinical Social Worker pursuant to Business and Professions Code, Section 4996.18.	1. Twelve semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services; or 2. Two years of experience in designing and/or implementing behavior modification intervention services.
Behavior Management Consultant: (Psychologist)	Business and Professions Code, §2940-2948 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Behavior Management Consultant: Licensed Clinical Social Worker	Business and Professions Code §§4996-4996.2 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Behavior Management	Business and Professions	N/A	N/A

Consultant: Marriage Family Child Counselor	Code §§4980-4981 As appropriate, a business license as required by the local jurisdiction where the business is located.		
Licensed Psychiatric Technician	Business and Professions Code §4500 et seq. Possesses a valid psychiatric technician's license issued by the California State Board of Vocational Nurse and Psychiatric Technician Examiners As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Client/Parent Support Behavior Intervention Training	Licensed in accordance with Business and Professions Code as appropriate to the skilled professions of staff.	Refer to "Other Standard."	Client/Parent Support Behavior Intervention Training services may be provided by a Behavior Analyst, Behavior Analyst, Associate Behavior Analyst, Psychologist, Psychiatric Technician or Psychiatrist. Specific qualifications and training of providers are as specified in the requirements established in this section.

	As appropriate, a business license as required by the local jurisdiction where the business is located.		
Behavior Analyst	Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff. As appropriate, a business license as required by the local jurisdiction where the business is located.	Certification by the national Behavior Analyst Certification Board.	N/A
Family Counselor (MFCC), Clinical Social Worker (CSW)	Valid license with the California Board of Behavioral Science Examiners As appropriate, a business license as required by the local jurisdiction where the business is located. MFCC: Business and Professions Code §§4980-4984.9	N/A	N/A

	CSW: Business and Professions Code §§4996-4997		
Parenting Support Services Provider	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.
Individual or Family Training Provider	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.
State-Operated Mobile Crisis Team	Licensed pursuant to Business and Professions Code as appropriate to the skilled professions staff assigned to the team.	Certified as appropriate to the skilled professions staff assigned to the team.	Program utilizes licensed and/or certified state personnel as appropriate to provide, develop and implement individualized crisis behavioral services plans. Specific qualifications and training of personnel per agency guidelines consistent with requirements for Behavioral Specialist I, Psychologist, Psychiatric Technician, Psychiatric Technician Instructor, and Registered Nurse. This provider is authorized under WIC 4474.2.
Associate Behavior Analyst	No state licensing category. As appropriate, a business license as	Certification by the national Behavior Analyst Certification Board	Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.

	required by the local jurisdiction where the business is located.		
Behavioral Technician /Paraprofessional	No state licensing category As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant. (1) Has a High School Diploma or the equivalent, has completed 30 hours of competency-based training designed by a certified behavior analyst, and has six months experience working with persons with developmental disabilities; or (2) Possess an Associate's degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and has six months experience working with persons with developmental disabilities.
Community Crisis Homes	Licensed Adult Residential Facility or group home by the Department of Social Services pursuant to Health and Safety Code §§ 1567.80 - 1567.87. As appropriate, a business license as required by the local jurisdiction where the business is located.	Certified by the Department of Developmental Services pursuant to WIC 4698	In addition to the requirements in Title 22, CCR, §§85000-85092, requirements from Title 17, CCR, §§59004 - 59005 also apply. Administrator Qualifications (a) An administrator must: (1) Have a minimum of two years of prior experience providing direct care or supervision to individuals with developmental disabilities and be one of the following: (A) A registered behavior technician. (B) A licensed psychiatric technician. (C) A qualified behavior modification professional. (b) An administrator must complete the Residential Services Orientation as required per Section 56003(b). Direct Care Staff Qualifications (a) A direct care staff person must:

			(1) Have at least six months' prior experience providing direct care to individuals with developmental disabilities who have challenging behavior service needs and (2) Become a registered behavior technician within twelve months of initial employment or be a qualified behavior modification professional. (b) A direct care lead staff person must: (1) Have at least one-year prior experience providing direct care to individuals with developmental disabilities with challenging behavior service needs and (2) Become a registered behavior technician within 60 days of initial employment or be a qualified behavior modification professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Habilitation – Behavioral Intervention Services providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Crisis Intervention Facilities	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Respite Care**
Service Definition (Scope)*:*	

Intermittent or regularly scheduled temporary non-medical care (with the exception of colostomy, ileostomy, catheter maintenance, and gastrostomy) and supervision provided in the recipient's own home or in an approved out of home location to do all of the following:

- Assist family members in maintaining the recipient at home;
- Provide appropriate care and supervision to protect the recipient's safety in the temporary absence of family members;
- Temporarily relieve family members from the constantly demanding responsibility of caring for a recipient; and
- Attend to the recipient's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by family members.

Respite may only be provided when the care and supervision needs of a consumer exceed that of a person of the same age without developmental disabilities.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

While there is no limit on the duration that respite services that can be provided, FFP will not be claimed for respite service provided beyond 30 consecutive days.
Respite care may be provided in the following locations:
Private residence

- Residential facility licensed by the Department of Social Services.
- Respite facility licensed by the Department of Social Services
- Other community setting approved by the State that is not a private residence, such as:
  - Adult Family Home/Family Teaching Home
  - Certified Family Homes for Children
  - Adult Day Care Facility
  - Camp
  - Licensed Preschool

A regional center may offer family members or adult consumers the option to self-direct their own respite services.

Respite services do not duplicate services provided under the Individuals with Disabilities Education (IDEA) Act of 2004.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any

individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross; and has the skill, training, or education necessary to perform the required services.
Respite Agency	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	The agency director shall possess at a minimum: 1. A bachelor's degree and a minimum of 18 month's experience in the management of a human services delivery system, or; 2. Five years of experience in a human services delivery system, including at least two years in a management or supervisory position.
Adult Day Care Facility	Health and Safety Code §§ 1500 - 1567.8 As appropriate, a business license as required by the local jurisdiction where the	N/A	The administrator shall have the following qualifications: 1. Attainment of at least 18 years of age. 2. Knowledge of the requirements for providing the type of care and supervision needed by clients, including ability to communicate with such clients. 3. Knowledge of and ability to comply with applicable law and regulation.

	business is located.		4. Ability to maintain or supervise the maintenance of financial and other records. 5. Ability to direct the work of others, when applicable. 6. Ability to establish the facility's policy, program and budget. 7. Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff, if applicable to the facility. 8. A baccalaureate degree in psychology, social work or a related human services field and a minimum of one-year experience in the management of a human services delivery system; or three years of experience in a human services delivery system including at least one year in a management or supervisory position and two years of experience or training in one of the following: A. Care and supervision of recipients in a licensed adult day care facility, adult day support center or an adult day health care facility. B. Care and supervision of one or more of the categories of persons to be served by the center. The licensee must make provision for continuing operation and carrying out of the administrator's responsibilities during any absence of the administrator by a person who meets the qualification of an administrator.
Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)	FFA licensed pursuant to Health and Safety Code §§1500-1567.8 provides statutory authority for DSS licensing of facilities identified in the	Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes.	Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA's, certification and use of homes, FFA administrator qualifications: (1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or,

	CA Community Care Facilities Act. As appropriate, a business license as required by the local jurisdiction where the business is located.		(2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position. Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).
Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only) Payment for this service will not be duplicated or supplanted through Medicaid funding.	Health and Safety Code §§1500-1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR §§89200-89587.1 Regulations adopted by DSS to specify requirements for licensure of Foster Family Homes. Qualifications/Requirements for FFH providers: 1. Comply with applicable laws and regulations and: 2. Provide care and supervision to meet the child's needs including communicating with the child; 3. Maintain all child records, safeguard cash resources and personal property; 4. Direct the work of others in providing care when applicable, 5. Apply the reasonable and prudent parent standard; 6. Promote a normal, healthy, balanced, and supported childhood experience and treat a child as part of the family; 7. Attend training and professional development; 8. Criminal Records/Child Abuse Registry clearance; 9. Report special incidents; 10. Ensure each child's personal rights; and, 11. Maintain a clean, safe, health home environment.
Respite Facility; Residential Facility: Small	Health and Safety Code §§1500-1567.8	N/A	Title 22, CCR §§ 83000-83088.

Family Homes (Children Only)	As appropriate, a business license as required by the local jurisdiction where the business is located.		Regulations adopted by DSS to specify requirements for licensure of Small Family Homes. Licensee/Administrator Qualifications ▪ Criminal Records/Child Abuse Index Clearance; ▪ At least 18 years of age; ▪ Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours is not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted: o Child Development; o Recognizing and/or dealing with learning disabilities; o Infant care and stimulation; o Parenting skills; o Complexities, demands and special needs of children in placement; o Building self-esteem, for the licensee or the children; o First aid and/or CPR; o Bonding and/or safeguarding of children's property; o Ability to keep financial and other records; o Ability to recruit, employ, train, direct the work of and evaluate qualified staff.
Respite Facility; Residential Facility: Group Homes (Children Only)	Health and Safety Code §§ 1500-1567.8 As appropriate, a business license as required by the local jurisdiction	N/A	Title 22, CCR, § 84000-84808 Regulations adopted by DSS to specify requirements for licensure of Group Homes. Administrator Qualifications: 1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children;

	where the business is located.		2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above); 3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or 4.Completed high school, or equivalent, plus at least three years administrative - or supervisory experience (as above); and, 5. Criminal Records/Child Abuse Registry Clearance
Respite Facility; Residential Facility: Adult Residential Facilities (ARF)	Health and Safety Code §§ 1500 through 1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception. Administrator Qualifications ▪ At least 21 years of age; ▪ High school graduation or a GED; ▪ Complete a program approved by DSS that consists of 35 hours of classroom instruction o 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities; o 3 hrs. in business operations; o 3 hrs. in management and supervision of staff; o 5 hrs. in the psychosocial needs of the facility residents; o 3 hrs. in the use of community and support services to meet the resident's needs; o 4 hrs. in the physical needs of the facility residents; o 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents; o 4 hrs. on admission, retention, and assessment procedures; ▪ Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%.

			▪ Criminal Record/Child Abuse Registry Clearance. Additional Administrator Qualifications may also include: ▪ Has at least one year of administrative and supervisory experience in a licensed residential program for persons ▪ with developmental disabilities, and is one or more of the following: (A) A licensed registered nurse. (B) A licensed nursing home administrator. (C) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities. (D) An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs.
Respite Facility; Residential Facility: Residential Care Facility for the Elderly (RCFE)	Health and Safety Code §§1569-1569.889 provides statutory authority for licensing of RCFEs. Identified as the CA Residential Care Facilities for the Elderly Act. As appropriate, a business license as required by the local jurisdiction where the	N/A	Title 22, CCR, §§87100-87793: Establish licensing requirements for facilities where 75 percent of the residents are sixty years of age or older. Younger residents must have needs compatible with other residents. Administrator Qualifications: 1. Knowledge of the requirements for providing care and supervision appropriate to the residents. 2. Knowledge of and ability to conform to the applicable laws, rules and regulations. 3. Ability to maintain or supervise the maintenance of financial and other records. 4. Ability to direct the work of others. 5. Good character and a continuing reputation of personal integrity. 6. High school diploma or equivalent. 7. At least 21 years of age. 8. Criminal Record Clearance.

	business is located.		
Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs	Health and Safety Code §§1500-1569.87 Appropriate license DSS CCLD as to type of facility As appropriate, a business license as required by the local jurisdiction where the business is located.		Welfare and Institutions Code, § 4684.50 et seq. **The administrator must:** 3. Complete the 35-houradministrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception, 4. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following: e. A licensed registered nurse. f. A licensed nursing home administrator. g. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities. h. An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs.
Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	AFH Title 17, CCR, §56088 Authorizes the FHA to issue a Certificate of Approval to each family home which has: 1. Completed the criminal record review	Welfare and Institutions Code 4689.1-4689.6 provides statutory authority for FHA. FHA employs sufficient staff with the combined experience, training and education to perform the following duties: 1. Administration of the FHA; 2. Recruitment of family homes; 3. Training of FHA staff and family homes;

		2. Been visited by the FHA and a determination ensuring safe and reasonable and the prospective providers experience, knowledge, cooperation, history and interest to become an approved family home. 3. Completed required orientation and training.	4. Ensuring an appropriate match between the needs and preferences of the consumer and the family home; 5. Monitoring of family homes; 6. Provision of services and supports to consumers and family homes which are consistent with the consumer's preferences and needs and the consumer's IPP; and 7. Coordination with the regional center and others. In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.
Camping Services	As appropriate, a business license as required by the local jurisdiction where the business is located.	The camp submits to the local health officer either 1) Verification that the camp is accredited by the American Camp Association or 2) A description of operating procedures that addresses areas including supervisor qualifications and staff skill verification criteria.	Camp Director Qualifications: must be at least 25 years of age, and have at least two seasons of administrative or supervisory experience in camp activities. Health Supervisor (physician, registered nurse or licensed vocational nurse) employed full time will verify that all counselors have been trained in first aid and CPR.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

All respite providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care Facilities	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers	Annually

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Supported Employment – Individual Services

Service Definition (Scope)*:*

Supported employment services are defined in California Welfare and Institutions Code § 4851 (n)(s) as; paid work that is integrated in the community for individuals with developmental disabilities. Individual services means job coaching and other supported employment services for regional center-funded consumers in a supported employment placement at a job coach-to-consumer ratio of one-to-one, and that decrease over time until stabilization is achieved. Individualized services may be provided on or off the jobsite. These services are received by eligible adults who are employed in integrated settings in the community. These individuals are unable to maintain this employment without an appropriate level of ongoing employment support services. Transportation services are not included under supported employment individual services.

Supported Employment- Individual Services (defined in California Welfare and Institutions Code §4851(n)(s).

- Training and supervision in addition to the training and supervision the employer normally provides to employees.
- Support services to ensure job adjustment and retention, provided on an individual basis in the community, as defined in California Welfare and Institutions Code §4851(q):

- Job development - The process of working with a consumer, based on the individuals interests and abilities to identify potential jobs, meet with the hiring business, and assist the consumer to apply for and compete for the job.
- Job analysis - Classifying each of the required duties of a job to identify the support needed by the consumer.
- Training in adaptive functional skills
- Social skill training
- Ongoing support services - Services that are provided, typically off the job, to assist a consumer with concerns or issues that could affect his or her ability to maintain employment.
- Family counseling necessary to support the individual's employment
- Advocacy related to the employment, such as assisting individuals in understanding their benefits
- Advocacy or intervention to resolve problems affecting the consumer's work adjustment or retention.

- Recipients receiving individual services normally earn minimum wage or above and are on the employer's payroll. Individuals receiving these services usually receive supervision 5-20% of the time by the program. The remainder of the time, the employer provides all supervision and training.

The above described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17).

The reimbursement for Supported Employment (Individual Services) includes incentive payments for measurable milestones identified below:

1. A one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2. An additional one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3. An additional one-time payment made to a provider when an individual has been employed consecutively for one year.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or

2. Payments that are passed through to users of supported employment services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any

individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supported Employment Programs	No state licensing category. Federal/State Tax Exempt Letter. As appropriate, a business license as required by the local jurisdiction where the business is located.	Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services pursuant to Title 17 § 58810(f)(1)(2).	N/A

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supported Employment Programs	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Supported Employment Programs	Commission on Accreditation of Rehabilitation Facilities (CARF)	Within four years at start-up; every one to three years thereafter

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Prevocational Services**
Service Definition (Scope)*:*	

Prevocational services are services that are delivered for the purpose of furthering habilitation goals of learning and work experience through a habilitation service plan required by 17 CCR § 58812 to outline a specific path to competitive, integrated employment in the community. The service plan is to be reviewed not less than annually or more frequently if requested by the individual.

Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community work place conduct and dress; ability to follow directions; ability to attend to asks; work place problem solving skills and strategies; general work place safety and mobility training. Additionally, both work adjustment and supportive habilitation services as defined in Title 17 CCR § 58820 (c)(2), should allow for the development of productive skills, physical and psychomotor skills, interpersonal and communicative skills, health and hygiene maintenance, personal safety practices, self-advocacy training, and other skills aimed at maintaining a job and as outlined in the individual's person-centered services and supports plan. Individuals may be compensated based upon their performance and upon prevailing wage. However, compensation is not the sole purpose of participation in this service.

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

Transportation services are not included under Prevocational Services.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or payments that are passed through to users of supported employment services.

The above-described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)).

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Work Activity Program	Facility license (Health and Safety Code §§ 1500-1567.8) if applicable Federal/State Tax Exempt Letter. As appropriate, a business license as required by the local jurisdiction where the business is located.	Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services.	N/A
Supported Employment Programs (Agency)	No state licensing category. Federal/State Tax Exempt Letter. As appropriate, a business license as required by the local jurisdiction where the business is located.	Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services pursuant to Title 17 § 58810(f)(1)(2).	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Work Activity Programs	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Work Activity Programs	Commission on Accreditation of Rehabilitation Facilities (CARF)	Within four years at start-up; every one to three years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Homemaker**

Service Definition (Scope)*:*

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemaker services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	1915(i) Homemaker services will be a continuation of services beyond the amount, duration and scope of the Personal Care Services Program State Plan benefit.
☒	Medically needy *(specify limits):*
	1915(i) Homemaker services will be a continuation of services beyond the amount, duration and scope of the Personal Care Services Program State Plan benefit.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Individual providers of homemaker services shall have the ability to maintain, strengthen, or safeguard the care of individuals in their homes.
Service Agency	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Must employ, train and assign personnel who maintain, strengthen, or safeguard the care of individuals in their homes.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Individual and Service Agency	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Home Health Aide

Service Definition (Scope)*:*

Services defined in 42 CFR §440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. Home health aide services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	1915(i) Home Health Aide services will be a continuation of services beyond the amount, duration and scope of the State Plan benefit.
☒	Medically needy *(specify limits):*
	1915(i) Home Health Aide services will be a continuation of services beyond the amount, duration and scope of the State Plan benefit.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home Health Agency	Health and Safety Code §§1725-1742 As appropriate, a business license as required by the local jurisdiction where the business is located.	Medi-Cal certification using Medicare standards, Title 22, CCR, §51217.	N/A
Home Health Aide	Health and Safety Code §§1725-1742	Title 22, CCR § 74746 Complete a training program	N/A

	As appropriate, a business license as required by the local jurisdiction where the business is located.	approved by the California Department of Public Health and is certified pursuant to Health and Safety Code § 1736.1.	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home Health Agency, Home Health Aide	California Department of Public Health Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	No less than every three years Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Community Based Adult Services**

Service Definition (Scope)*:*

Services furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in the community, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service. Community Based Adult Services will not supplant services available through the approved Medicaid State plan, 1115 Medi-Cal 2020 Demonstration Waiver or the EPSDT benefit.

Transportation between the individual's place of residence and the community based adult services center will be provided as a component part of community based adult services. The cost of this transportation is included in the rate paid to providers of community based adult services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	1915(i) Community Based Adult Services will be a continuation of services beyond the amount, duration and scope of State Plan and/or 1115 demonstration benefit.
☒	Medically needy *(specify limits):*
	1915(i) Community Based Adult Services will be a continuation of services beyond the amount, duration and scope of State Plan and/or 1115 demonstration benefit.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Day Health Care Center	Health and Safety Code §§1570-1596.5 An appropriate business license as required by the local jurisdiction where the agency is located.	Title 22, CCR, §54301	Title 22, CCR, §§ 78201-78233

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Day Health Care Center	California Department of Public Health (Licensing) California Department of Aging (Certification) Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service;	At least every two years At least every two years Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

	the staff qualifications and duty statements; and service design.	

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Personal Emergency Response System**

Service Definition (Scope)*:*

PERS is a 24-hour emergency assistance service which enables the recipient to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the recipient and includes training, installation, repair, maintenance, and response needs. The following are allowable:
1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company;
10. Other electronic devices/services designed for emergency assistance.

PERS services are limited to those individuals who have no regular caregiver or companion for periods of time, and who would otherwise require extensive routine supervision. By providing immediate access to assistance, PERS services prevent institutionalization of these individuals. PERS services will only be provided as a service to individuals in a non-licensed environment.

All items shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers where possible.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*

☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Other - Personal Emergency Response Systems	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	Certification / registration as appropriate for the type of system being purchased.	Providers shall be competent to meet applicable standards of installation, repair, and maintenance of emergency response systems. Providers shall also be authorized by the manufacturer to install, repair, and maintain such systems if such a manufacturer's authorization program exists. Providers of human emergency response services shall possess or have employed persons who possess current licenses, certifications or registrations as necessary and required by the State of California for persons providing personal emergency response services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Personal Emergency Response Systems	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Vehicle Modification and Adaptation**

Service Definition (Scope)*:*

Vehicle modification and adaptations are devices, controls, or services which enable recipients to increase their independence or physical safety, and which allow the recipient to live in their home. The repair, maintenance, installation, and training in the care and use, of these items are included.

Vehicle adaptations must be performed by the manufacturer's authorized dealer. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

The following types of modifications or adaptations to the vehicle are allowable:

1. Door handle replacements;
2. Door widening;
3. Lifting devices;
4. Wheelchair securing devices;
5. Adapted seat devices;
6. Adapted steering, acceleration, signaling, and braking devices; and
7. Handrails and grab bars

Modifications or adaptations to vehicles shall be included if, on an individual basis, the cost effectiveness of vehicle adaptations, relative to alternative transportation services, is established. Adaptations to vehicles are limited to vehicles owned by the recipient, or the recipient's family and do not include the purchase of the vehicle itself.

The recipient's family includes the recipient's biological parents, adoptive parents, stepparents, siblings, children, spouse, domestic partner (in those jurisdictions in which domestic partners are legally recognized), or a person who is legal representative of the recipient.

Vehicle modifications and adaptations will only be provided when they are documented in the individual plan of care and when there is a written assessment by a licensed Physical Therapist or a registered Occupational Therapist.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Vehicle Modification and Adaptation	No state licensing category. An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	Registration with the California Department of Consumer Affairs, Bureau of Automotive Repairs.	Providers shall be competent to meet applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Vehicle Modification and Adaptation	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Speech, Hearing and Language Services**

Service Definition (Scope)*:*

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

These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan

will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Speech, Hearing and Language services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Speech Pathologist	Business & Professions Code §§ 2532-2532.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Audiology	Business & Professions Code §§ 2532-2532.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A

Hearing and Audiology Facilities	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	An audiology facility: 1. Employs at least one audiologist who is licensed by the Speech Pathology and Audiology Examining Committee of the Medical Board of California; and 2. Employs individuals, other than 1. above, who perform services, all of whom shall be: • Licensed audiologists; or Obtaining required professional experience, and whose required professional experience application has been approved by the Speech Pathology and Audiology Examining Committee of the Medical Board of California.
Speech-Language Pathology Assistant (Agency)	Registered as a Speech-Language Pathology Assistant by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs, pursuant to Business and Professions Code §2538-2538.7 and Title 16 CCR § 1399.170.11. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Minimum continuing professional development requirements for the speech-language pathology assistant, of 12 hours in a two-year period.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Speech, Hearing and Language providers	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Speech Pathologist and Speech Language Pathologist Assistant	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board	Biennially.
Audiology	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board	Biennially if non-dispensing audiologist; annually if dispensing.
Hearing and Audiology Facilities	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board	Biennially.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Dental Services
Service Definition (Scope)*:*	
Dental services are defined in Title 22, California Code of Regulations, Section 51059 as professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls. These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Dental Services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Dentist	Business & Professions Code §§ 1600-1976 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Dentists	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Dentists	Dental Board of California	Biennially

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Optometric/Optician Services

Service Definition (Scope)*:*

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

These services will be provided to individuals age 21 and older as described in the approved State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Optometric/Optician services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Orthoptic Technician	Business and Professions Codes in Chapter 7, Article 3 Sections 3041, 3041.3, 3056, 3057	An orthoptic technician is validly certified by the American Orthoptic Council	N/A
Optometrist	An optometrist is validly licensed as an optometrist by	N/A	N/A

	the California State Board of Optometry As appropriate, a business license as required by the local jurisdiction where the business is located.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Optometric/Optician service providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Orthoptic Technician	American Orthoptic Council	Every three years
Optometrist	California State Board of Optometry	Biennially

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Prescription Lenses and Frames**

Service Definition (Scope)*:*

Prescription Lens/Frames are defined in Title 22, California Code of Regulations, Section 51162. Eyeglasses, prosthetic eyes and other eye appliances means those items prescribed by a physician or optometrist for medical conditions related to the eye.

These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Prescription Lenses and

Frames will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Dispensing Optician	Business and Professions Code §§ 2550-2560. As appropriate, a business license as required by the local jurisdiction where the business is located.	Registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California	N/A

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Prescription Lens/ Frame providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Dispensing Optician	Medical Board of California	Biennially

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Psychology Services**

Service Definition (Scope)*:*

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

These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Psychology Services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Clinical Psychologist	Business and Professions Code, §§2940-2948 As appropriate, a business license as	N/A	N/A

	required by the local jurisdiction where the business is located.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Clinical Psychologists	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Clinical Psychologist	Board of Psychology	Biennially

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Chore Services**

Service Definition (Scope)*:*

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, and minor repairs such as those which could be completed by a handyman. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual	As appropriate for the services to be done. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Individual chore service providers shall possess the following minimum qualifications: 1. The ability to perform the functions required in the individual plan of care; Demonstrate dependability and personal integrity.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Individual	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Communication Aides**
Service Definition (Scope)*:*	
Communication aides are those human services necessary to facilitate and assist persons with hearing, speech, or vision impairment to be able to effectively communicate with service providers,	

family, friends, co-workers, and the general public. The following are allowable communication aides, as specified in the recipient's plan of care:

1. Facilitators;
2. Interpreters and interpreter services; and
3. Translators and translator services.

Communication aide services include evaluation for communication aides and training in the use of communication aides.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Facilitators	No state licensing category. An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	N/A	Qualifications and training as appropriate.
Interpreter	No state licensing category. An appropriate business license as required by the local	N/A	1. Fluency in both English and a language other than English; and The ability to read and write accurately in both English and a language other than English.

	jurisdiction for the adaptations to be completed.		
Translator	No state licensing category. An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	N/A	1. Fluency in both English and a language other than English; and 2. The ability to read and write accurately in both English and a language other than English.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Communication Aid providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Environmental Accessibility Adaptations**

Service Definition (Scope)*:*

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual,

such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded form this benefit. All services shall be provided in accordance with applicable State or local building codes.

It may be necessary to make environmental modifications to an individual's home before he/she transitions from an institution to the community. Such modifications may be made while the person is institutionalized. Environmental modifications, included in the individual's plan of care, may be furnished up to 180 days prior to the individual's discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is determined eligible for 1915(i) State Plan Services.

In the event an individual dies before the relocation can occur, but after the modifications have been made, the State will claim FFP at an administrative rate for services that would have been necessary for relocation to have taken place.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Contractor	A current license, certification or registration with the State of California as appropriate for the type of modification being purchased.	See "License"	N/A

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification	Frequency of Verification *(Specify):*

	(Specify):	
Contractor appropriate for the type of adaption to be completed.	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing as needed/ required.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Non-Medical Transportation**

Service Definition (Scope)*:*

Service offered in order to enable individuals eligible for 1915(i) State Plan Services to gain access to other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them.

Non-medical transportation services shall be offered in accordance with the individual's plan of care and shall include transportation aides and such other assistance as is necessary to assure the safe transport of the recipient. Private, specialized transportation will be provided to those individuals who cannot safely access and utilize public transportation services (when available.) Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. A regional center may offer family members or adult consumers the option to self-direct their own non-medical transportation services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual Transportation Provider	Valid California driver's license As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Welfare and Institutions Code Section 4648.
Transportation Company: Transportation Broker; Transportation Provider–Add-itional Component	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Welfare and Institutions Code Section 4648.3.
Public Transit Authority	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Welfare and Institutions Code Section 4648.3.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Transportation Providers	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Nutritional Consultation**

Service Definition (Scope)*:*

Nutritional Consultation includes the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of the consumers. These services are consultative in nature and do not include specific planning and shopping for, or preparation of meals for consumers.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Dietitian; Nutritionist	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	Dietician: Valid registration as a member of the American Dietetic Association	Nutritionist must possess a Master's Degree in one of the following: a. Food and Nutrition; b. Dietetics; or c. Public Health Nutrition; or is employed as a nutritionist by a county health department.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Nutritional Consultation providers	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license,	Verified upon application for vendorization and ongoing thereafter through

	credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Skilled Nursing**

Service Definition (Scope)*:*

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. 1915(i) HCBS SPA Skilled Nursing Services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

A regional center may offer family members or adult consumers the option to self-direct their own skilled nursing services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Registered Nurse (RN)	Business and Professions Code, §§ 2725-2742 Title 22, CCR, § 51067	N/A	N/A

	As appropriate, a business license as required by the local jurisdiction where the business is located.		
Licensed Vocational Nurse (LVN)	Business and Professions Code, §§ 2859-2873.7 Title 22, CCR, § 51069 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Home Health Agency: RN or LVN	Title 22, CCR, §§ 74600 et. seq. RN: Business and Professions Code, §§ 2725-2742 Title 22, CCR, § 51067 LVN: Business and Professions Code, §§ 2859-2873.7 Title 22, CCR, § 51069 As appropriate, a business license as required by the	Medi-Cal Certification using Medicare standards Title 22, CCR, §§ 51069-51217.	N/A

	local jurisdiction where the business is located.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Skilled Nursing Providers	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Registered Nurse	Board of Registered Nursing, Licensing and regional centers	Every two years
Licensed Vocational Nurse	Board of Vocational Nursing and Psychiatric Technicians, Licensing and regional centers	Every two years

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Specialized Medical Equipment and Supplies**

Service Definition (Scope)*:*

Specialized Medical Equipment and Supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the approved Medicaid State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the approved Medicaid State plan. The repair, maintenance, installation, and training in the care and use, of these items is also included. Funding for items reimbursed by this State Plan Amendment are in addition to any medical equipment and supplies furnished under the approved Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design, and installation, and must meet Underwriter's Laboratory or Federal

Communications Commission codes, as applicable. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Durable Medical Equipment Dealer	If applicable, a current license with the State of California as appropriate for the type of equipment or supplies being purchased. As appropriate, a business license as required by the local jurisdiction where the business is located.	If applicable, a current certification with the State of California as appropriate for the type of equipment or supplies being purchased.	Be authorized by the manufacturer to install, repair and maintain such systems if such a manufacturer's program exists.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Specialized Medical Equipment and Supplies Providers	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license,	Verified upon application for vendorization and ongoing thereafter through

	credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Transition Set-Up Expenses**

Service Definition (Scope)*:*

Transition/Set Up Expenses are one-time, non-recurring set-up expenses to assist individuals who are transitioning from an institution to their own home. These expenses fund some of the initial set-up costs that are associated with obtaining and securing an adequate living environment and address the individual's health and safety needs when he or she enters a new living environment.

"Own home" is defined as any dwelling, including a house, apartment, condominium, trailer, or other lodging that is owned, leased, or rented by the individual.

This service includes necessary furnishings, household items and services that an individual needs for successful transition to community living and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Moving expenses;
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy;
- Set up fees or non-refundable deposits for utilities (telephone, electricity, heating by gas);
- Essential furnishings to occupy and use a community domicile, such as a bed, table, chairs, window blinds, eating utensils, food preparation items, etc.

These services exclude:

- Items designed for diversionary/recreational/entertainment purposes, such as hobby supplies, television, cable TV access, or VCRs and DVDs.
- Room and board, monthly rental or mortgage expense, regular utility charges, household appliances, and food.

Items purchased through this service are the property of the individual receiving the service and the individual takes the property with him/her in the event of a move to another residence.

Some of these expenses may be incurred before the individual transitions from an institution to the community. In such cases, the Transition/Set Up expenses incurred while the person was institutionalized are not considered complete until the date the individual leaves the institution. Transition/Set Up expenses included in the individual's plan of care may be furnished up to 180 days prior to the individual's discharge from an institution. However, such expenses will not be

considered complete until the date the individual leaves the institution and is determined eligible for 1915(i) State Plan Services.

In the event an individual dies before the relocation can occur, but after the expenses have been incurred, the State will claim FFP at the administrative rate for services which would have been necessary for relocation to have taken place.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Public Utility Agency Retail and Merchandise Company Health and Safety agency Individual (landlord, property management) Moving Company	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Transition/Set Up Providers	Regional centers, through the vendorization process, verify providers meet requirements/	Verified upon application for vendorization and

	qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Community Based Training Services**

Service Definition (Scope)*:*

Community-based training service is a participant-directed service that allows recipients the opportunity to customize day services to meet their individualized needs. As determined by the person-centered individual program planning process, the service may include opportunities and assistance to: further the development or maintenance of employment and volunteer activities; pursue post-secondary education; and increase recipients' ability to lead integrated and inclusive lives. These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. These services enable the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	Community-based training services are limited to a maximum of 150 hours per quarter.
☒	Medically needy *(specify limits):*
	Community-based training services are limited to a maximum of 150 hours per quarter.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community-Based Training Provider	As appropriate, a business license as required by the	N/A	Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in

	local jurisdiction where the business is located.		accordance with the individual program plan.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Community-Based Training Provider	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Financial Management Services**

Service Definition (Scope)*:*

Financial Management Services (FMS) are designed to serve as a fiscal intermediary that performs financial transactions (paying for goods and services and/or processing payroll for adult consumers' or their families' workers included in the IPP) on behalf of the consumer. FMS is an important safeguard because it ensures that consumers are in compliance with Federal and state tax, labor, workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents.

All FMS services shall:

1. Assist the family member or adult consumer in verifying worker citizenship status.
2. Collect and process timesheets of workers.
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
4. Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
5. Maintain all source documentation related to the authorized service(s) and expenditures.
6. Maintain a separate accounting for each participant's participant-directed funds.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Financial Management Services Provider	Business license, as appropriate		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All FMS providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Intensive Transition Services**

Service Definition (Scope)*:*

Intensive Transition Services (ITS) is a service providing support to those individuals who have been assessed to have complex behavioral health needs and who have transitioned into a community living option. Provision of Intensive Transition Services will begin once the individual has transitioned into the community setting. The IPP team determines if ITS would be of benefit to the consumer based on an individualized need of a more intensive service that would make the transition possible.

ITS provides a team that will work in a person-centered approach to create a network of resources that will eventually allow the individual to live independently in the community. Services are directly provided by the team members consisting of the following:

- Assessment – Initial and ongoing assessment to provide the below services in an individualized approach and continuously pivot based on the ongoing needs;
- Substance use recovery treatment;
- Anger management;
- Self-advocacy;
- Medication management;
- Health and dietary education;
- Sex education/fostering healthy relationships;
- Behavioral support and modification training for the individual - ITS engages with service providers and circle of support to provide consultative information on managing the consumers behavior if deemed appropriate and necessary to support the consumers transition;
- Outpatient therapy – counseling by professionals who specialize with intellectual/developmental disabilities crisis work;
- Co-occurring disorders integrated treatment – a treatment organizational approach that allows all counseling, trainings, and treatments to work cohesively together in order to address every impacting disorder to successfully transition;
- Transition Planning – Ongoing planning throughout the services that adjusts based on progression of the individual.

ITS team members operate 24 hours a day, 7 days a week, including holidays, and are available in the event of a crisis.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	Services shall not exceed 24 total months (may be non-consecutive), unless IPP team agreement coinciding with Department of Developmental Services director approval for additional time is granted to ensure a successful transition into the community.
☒	Medically needy (specify limits):
	Services shall not exceed 24 total months (may be non-consecutive), unless IPP team agreement coinciding with Department of Developmental Services director approval for additional time is granted to ensure a successful transition into the community.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Intensive Transition Services Agency (Agency)	N/A	N/A	ITS agency staff include a Board Certified Behavior Specialist, Transition/Care Coordinator, Program Director, Mental Health Professional, and Registered Nurse The agency shall employ staff who possess the skill, training and education necessary to support individuals with complex service needs during the transition.
Program Director (Agency)			Doctoral PhD or master's level Psychologist licensed in the state of practice or a licensed master's level therapist who holds a license in the state of practice. This may include: LPC, LSW, LICSW, or Licensed Behavioral Specialist where accepted with no less than 6 years' experience in the behavioral health field. These 6 years should be composed of a minimum of two years of experience in a mental health sett ing with individuals wi disabilities; and at program management experience. An unlicensed masters level staff can be considered with 10 or more years' experience outlined above with approval from the vendoring Regional Center.
Transition/Care Coordinator (Agency)	N/A	N/A	Must have bachelor's degree in social work, Psychology, or another human service-related field. No less than three years of experience in the behavioral health field with at least one year of experience in a mental health setting and one year working in a developmental disability setting.
Behavior Specialist (Agency)	Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.	Certification by the Behavior Analyst Certification Board and accredited by the National Commission for	Must demonstrate through the interview process, knowledge and experience working with both individuals who have an intellectual disability as well as a serious mental illness; have knowledge and be certified, in one of the established behavior modification techniques, such as Applied Behavioral Analysis (ABA), Functional Behavioral Analysis (FBA) as

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	As appropriate, a business license as required by the local jurisdiction where the business is located.	Certifying Agencies.	well as have experience with EBP such as CBT and Trauma Informed Care; and have prior experience providing clinical supervision to non-clinical staff. Valid CA driver's license and appropriate state and federal clearances.
Registered Nurse (Agency)	Licensed Registered Nurse by the Department of Consumer Affairs Board of Registered Nursing pursuant to Business and Professions Code §§ 2725-2742. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Work experience in either the intellectual disability or mental health system. Valid CA Driver's License and ability to pass appropriate state and federal clearances. Attachment 3.1 Page 86 c.4
Mental Health Professional (Agency)	Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code §§2940-2948 Or Licensed Clinical Social Worker by the California Board of	N/A	Must possess two years' experience designing and implementing behavior modification intervention services.

	Behavioral Science Examiners pursuant to Business and Professions Code §§4996-4996.2 Or Licensed Marriage Family Therapist by the Board of Behavioral Sciences pursuant to Business and Professions Code §4980 (b) As appropriate, a business license as required by the local jurisdiction where the business is located.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Intensive Transition Services (ITS) Agency	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and at least biennially thereafter.
Agency Providers	ITS Agency, Regional Center, through the annual quality assurance review and contract reviews when a new professional is hired.	Annually.

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Housing Access Services

Service Definition (Scope)*:*

Housing Access Services includes two components:

A) Individual Housing Transition Services. - These services provide direct support and assistance with activities and processes associated with an individual's preparation for and transition to housing. These services are:
   1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment includes collecting information on potential housing transition barriers, and identification of housing retention barriers.
   2. Assisting the individual in developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
   3. Assisting the individual with the housing application process. Assisting with the housing search process.
   4. Assisting the individual with identifying resources to cover set-up fees for utilities or service access, including telephone, electricity, heating and water, and services necessary for the individual's health and safety, consisting of pest eradication and one-time cleaning prior to occupancy.
   5. Assisting the individual with coordinating resources to identify and address conditions in the living environment prior to move-in that may compromise the safety of the consumer.
   6. Assisting the individual with details of the move including communicating with the landlord to negotiate a move-in date, reading and understanding the terms of the lease, scheduling set-up of utilities and services, and arranging the move of consumers' belongings.
   7. Assisting the individual with the development of a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

B) Individual Housing & Tenancy Sustaining Services - This service is made available to support individuals to maintain tenancy once housing is secured. The availability of ongoing housing-related services in addition to other long term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks. These tenancy support services are:
   1. Assisting the individual in the early detection and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
   2. Assisting the individual with education and training on the role, rights and responsibilities of the tenant and landlord.
   3. Coaching the individual on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
   4. Assisting the individual in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
   5. Assisting the individual with advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized.
   6. Assisting the individual with the housing recertification process.

7. Assisting the individual in reviewing, updating and modifying their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
8. Providing the individual with continuous training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Housing Access Services do not include payment for room and board.

Persons receiving Health Homes or California Community Transitions services will not receive this service unless additional Housing Access through the 1915i is necessary to maintain the consumers' health, safety and wellbeing in the home and/or community.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual/ Business entity	As appropriate, a business license as required by the local jurisdiction where the business is located	N/A	N/A
Business entity	As appropriate, a business license as required by the local jurisdiction where the business is located	N/A	N/A

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Individual	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and biennially thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Family Support Services**

Service Definition (Scope)*:*

Provide care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home. This service is provided in the recipient's own home or in an approved out of home location to do all of the following:

1. Assist family members in maintaining the recipient at home;
2. Provide appropriate care and supervision to protect the recipient's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a recipient; and
4. Attend to the recipient's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by family members.

Family support services may only be provided when the care and supervision needs of a consumer exceed that of a person of the same age without developmental disabilities. Additionally payment may only be made when the cost of the service exceeds the cost of providing services to a person of the same age without disabilities.

A regional center may offer family members the option to self-direct their own family support services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Child Day Care Facility; Child Day Care Center; Family Child Care Home (Individual/Agency)	Licensed Child Day Care Facility by the Department of Social Services pursuant to Health and Safety Code §§ 1596.90 – 1597.621 As appropriate, a business license as required by the local jurisdiction where the business is located.	Child Day Care Center: Title 22 CCR, §§101151-101239.2 Family Child Care Home: Title 22 CCR §§102351.1-102424	Licensing requirements listed under HSC 1596.95 The administrator shall have the following qualifications: 1. Attainment of at least 18 years of age. 2. Knowledge of the requirements for providing the type of care and supervision children need and the ability to communicate with such children. 3. Knowledge of and ability to comply with applicable law and regulation. 4. Ability to maintain or supervise the maintenance of financial and other records. 5. Ability to establish the center's policy, program and budget. 6. Ability to recruit, employ, train, direct and evaluate qualified staff.
Individual	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training. Must have the skill, training, or education necessary to perform the required services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Business entity	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design. Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.	Verified upon application for vendorization and biennially thereafter.

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Occupational Therapy
Service Definition (Scope)*:*	
Occupational Therapy services are defined in Title 22, California Code of Regulations, Sections 51085, and 51309 as services designed to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness or advanced age. Occupational therapy includes evaluation, treatment planning, treatment, instruction and consultative services. All medically necessary occupational therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Occupational therapy in this 1915i is only provided to individuals age 21 and over and only when the limits of occupational therapy services furnished under the approved state plan are exhausted. Occupational therapy services in the approved state plan are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: audiology, acupuncture, chiropractic, psychology, podiatry, and speech therapy or the amount determined medically necessary.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Occupational Therapist (Individual/Agency)	Occupational Therapist: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571		

	An appropriate business license as required by the local jurisdiction for the adaptations to be completed.		
Occupational Therapist Assistant (Agency)	Occupational Therapist Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571 An appropriate business license as required by the local jurisdiction for the adaptations to be completed.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Business entity	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and biennially thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Physical Therapy**
Service Definition (Scope)*:*	

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

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

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Physical Therapist (Individual/Agency)	Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1 An appropriate business license as required by the local jurisdiction for the adaptations to be completed.		

Physical Therapy Assistant (Agency)	Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy An appropriate business license as required by the local jurisdiction for the adaptations to be completed.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Business entity	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and biennially thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Family/Consumer Training**

Service Definition (Scope)*:*

Family/consumer support and training services are provided, as needed, in conjunction with extended state plan services in this 1915i. These services include training by licensed providers to maintain or enhance the long-term impact of treatment provided. This includes support or counseling for the consumer and/or family to ensure proper understanding of the treatment provided and what supports are needed in the recipient's home environment to enhance the treatments. These services will be provided to individuals age 21 and older.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any

individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist (Individual/Agency)	Dentist: Licensed Dentist by the Dental Board of California pursuant to Business and Professions Code§§1628-1636.6 Dental Hygienist: Licensed Dental Hygienist by the Dental Hygiene Committee of California pursuant to Business and Professions Code §§1900-1966.6 Marriage & Family Therapist (MFT): Licensed MFT by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4980-4989 Social Worker: Licensed Social Worker by the California Board of Behavioral		

	Sciences pursuant to Business and Professions Code §§4996-4997.1 Speech Therapist: Licensed Speech-Language Therapist by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board pursuant to Business and Professions Code §2532-2532.8 As appropriate, a business license as required by the local jurisdiction where the business is located.		
Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, Registered Nurse, Licensed Vocational Nurse, (Individual/Agency)	Occupational Therapist and Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571 Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1	N/A	

	Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1 Licensed Registered Nurse by the California Board of Registered Nursing pursuant to Business and Professions Code §§ 2725-2742 Licensed Vocational Nurse by the California Board of Vocational Nursing and Psychiatric Technicians pursuant to Business and Professions Code §§ 2859-2873.6 2873.7 As appropriate, a business license as required by the local jurisdiction where the business is located.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Business entity	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the	Verified upon application for vendorization and biennially thereafter.

	following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

2. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Any of the services identified in the 1915(i) section of the State Plan may be provided by a recipient's relative/legal guardian if the relative/legal guardian meets all specified provider qualifications. The selection of the relative/legal guardian as a provider will only be done pursuant to applicable law and the assessment and person-centered planning process. Regional centers will monitor, with DHCS and DDS oversight and monitoring, service provision and payment.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

○	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
◉	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*
	Participants who receive respite, financial management services, community-based training services, family support services, skilled nursing or non-medical transportation have the opportunity to direct those services.

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (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 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. As an alternative to only receiving services from regional center vendors, families and consumers will have decision-making authority and the freedom to directly control who provides their services and how they are provided.

For those participants who receive respite, 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 to exercise decision making authority over the provision of services.

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

◉	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all

	geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Respite	☒	☐
Community-Based Training Services	☒	☐
Skilled Nursing	☒	☐
Non-Medical Transportation	☒	☐
Family Support Services	☒	☐
Financial Management Services	☒	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
◉	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☒ Participant–Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:
   - Specifies the State plan HCBS that the individual will be responsible for directing;
   - Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
   - Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
   - Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
   - Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

Participants may choose to switch to non-participant-directed services at any time. In some instances, there may not be agreement with the decision to terminate participant-direction of services. In these instances, the regional center would issue a notice of action and the participant would have the opportunity for a fair hearing. 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 services.

8. Opportunities for Participant-Direction

a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
◉	Participants may elect participant-employer Authority *(Check each that applies):*	
	☒	**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.
	☒	**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.

b. **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

◉ The state does not offer opportunity for participants to direct a budget.
○ Participants may elect Participant–Budget Authority.
Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
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.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans:
    (a) address assessed needs of 1915(i) participants;
    (b) are updated annually; and
    (c) document choice of services and providers.
2. Eligibility Requirements:
    (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future;
    (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and
    (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Qualified Provider: Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. Administrative Authority: The SMA retains authority and responsibility for program operations and oversight.
6. Financial Accountability: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. Health and Welfare - The state:
    (a) identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death;
    (b) demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible;
    (c) ensures policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed;
    (d) establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement 1(a)	Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reviewed individual program plans (IPPs) that adequately addressed all the consumers' assessed needs. Numerator: Number of consumer IPPs reviewed that addressed all assessed needs Denominator: Total number of consumer IPPs reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed

Requirement 1(a)	Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of consumer IPPs that addressed all the consumer's identified health needs and safety risks. Numerator: Number of consumer IPPs reviewed that addressed all the consumer's identified health needs and safety risks

	Denominator: Total number of consumer IPPs reviewed that had identified health needs and safety risks
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed

Requirement 1(a)	**Service plans address assessed needs of 1915(i) participants**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of consumer IPPs that addressed all the consumer's goals. Numerator: Number of consumer IPPs reviewed that addressed all the consumer's goals Denominator: Total number of consumer IPPs reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring	DDS and DHCS

Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 1(a)	Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(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 IPP was necessary to address changing need
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 1(a)	**Service plans address assessed needs of 1915(i) participants**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of consumers 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 IPPs Denominator: Total number of consumer IPPs reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency	As needed.

	(of Analysis and Aggregation)	

Requirement 1(a)	Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of consumer IPPs developed in accordance with State policies and procedures. Numerator: Number of consumer IPPs developed in accordance with State policies and procedures Denominator: Total number of IPPs reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 1(b)	Service plans are updated annually.
Discovery	
Discovery Evidence	Number and percent of consumer IPPs that were reviewed or revised at required intervals (at least annually).

(Performance Measure)	Numerator: Number of consumer IPPs that were reviewed or revised at required intervals Denominator: Total number of IPPs reviewed that indicated a review or revision was required.
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 1(c)	Service plans document choice of services and providers.
Discovery	
Discovery Evidence *(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 indicating agreement with the services and providers. Denominator: Total number of consumer IPPs reviewed
Discovery Activity	Record reviews conducted during biennial collaborative monitoring reviews.

(Source of Data & sample size)	A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed

Requirement 2(a)	An evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of consumers with a timely needs-based evaluation prior to 1915(i) enrollment. Numerator: Number of consumers with a timely needs-based evaluation prior to 1915(i) enrollment Denominator: Total number of new 1915(i) enrollees
Discovery Activity *(Source of Data & sample size)*	DDS Client Master File
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS

Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 2(b)	**The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of needs-based evaluation conducted utilizing the process outlined in the 1915(i) SPA. Numerator: Number of consumer records reviewed that documented the needs-based evaluation utilizing the process outlined in the approved 1915 (i) SPA Denominator: Total number of consumer records reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DDS and DHCS

	remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 3		Providers meet required qualifications.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of licensed providers that initially and continually meet all required standards prior to furnishing Medicaid services Numerator: Number of licensed providers that initially and continually meet all required standards prior to furnishing Medicaid services Denominator: Number of all providers
	Discovery Activity *(Source of Data & sample size)*	Review of Vendor Master File records that indicate regional center verification of provider qualifications
	Monitoring Responsibilities	DDS

(Agency or entity that conducts discovery activities)	
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 3	Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of non-licensed/non-certified providers that initially and continually meet all required standards prior to furnishing State Plan services. Numerator: Number of non-licensed/non-certified providers who initially and continually meet all required standards prior to furnishing State Plan services Denominator: Number of all providers
Discovery Activity *(Source of Data & sample size)*	Review of Vendor Master File records that indicate regional center verification of provider qualifications
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS
Frequency	Monthly
Remediation	
Remediation Responsibilities	DDS

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 3	Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers licensed by the Department of Social Services (DSS) that initially and continually meet all required standards prior to furnishing State Plan services. Numerator: Number of DSS licensed providers that initially and continually meet all required standards prior to furnishing State Plan services. Denominator: Total number of providers licensed by DSS.
Discovery Activity *(Source of Data & sample size)*	DSS and Facilities Automated System
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DSS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS
Frequency	As needed.

	(of Analysis and Aggregation)	

Requirement 3		Providers meet required qualifications.
Discovery		
	Discovery Evidence *(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 are required to take the training
	Discovery Activity *(Source of Data & sample size)*	Review of Direct Service Professional (DSP) Training Program report
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS
	Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 4		Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery		
	Discovery Evidence	Number and percent of settings that meet the HCBS settings requirements. Numerator: Number of settings that meet the HCBS settings requirements Denominator: Number of settings reviewed

(Performance Measure)	
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 5	The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of policies and procedures reviewed by the Medicaid Agency found to be compliant. (Consolidated Measure across all HCBS programs) Numerator: Number and percent of policies and procedures reviewed by the Medicaid Agency found to be in compliance Denominator: Number of policies and procedures reviewed by the Medicaid Agency
Discovery Activity *(Source of Data & sample size)*	Review of policies and procedures to ensure compliance with federal commitment/requirements.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 5	The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of required coordination meetings conducted between the Medicaid Agency, DDS and DSS (as required). Numerator: Number of coordination meetings conducted between the Medicaid Agency, DDS and DSS as required Denominator: Total number of planned coordination meetings
Discovery Activity *(Source of Data & sample size)*	Notes resulting from meetings between the Medicaid Agency, DDS and DSS
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS, DHCS, and DSS
Frequency	At least quarterly.
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS, DHCS, and DSS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 5	**The SMA retains authority and responsibility for program operations and oversight.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of oversight/monitoring meetings conducted between DDS and the Medicaid Agency. (Consolidated Measure across all HCBS programs) Numerator: Number of required oversight/monitoring meetings conducted between DDS and the Medicaid Agency Denominator: Number of planned oversight meetings
Discovery Activity *(Source of Data & sample size)*	Notes from oversight/monitoring meets, conducted between Medicaid Agency and DDS
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	At least semi-annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency	As needed.

	(of Analysis and Aggregation)	

Requirement 5		The SMA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of DDS Quality Management Executive Committee (QMEC) Meetings conducted. Numerator: Number and percent of required oversight/monitoring meetings conducted between DDS and the Medicaid Agency Denominator: Number of planned oversight meetings
	Discovery Activity *(Source of Data & sample size)*	Notes from oversight/monitoring meets, conducted between Medicaid Agency and DDS
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
	Frequency	At least semi-annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
	Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 5		The SMA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence	Number and percent of DDS invoices reviewed to ensure expenditures are managed against approved limits.

	(Performance Measure)	Numerator = number of DDS invoices reviewed to ensure expenditures are managed against approved limits. Denominator = total number of invoices submitted by DDS.
	Discovery Activity *(Source of Data & sample size)*	DDS Invoices
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
	Frequency	
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
	Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 5	The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number of oversight/monitoring review reports reviewed by DHCS. Numerator = number of reports submitted to and reviewed by DHCS. Denominator = total number of reports submitted to DHCS. Record reviews conducted during state's biennial collaborative HCBS waiver monitoring reviews.
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during state's biennial collaborative HCBS waiver monitoring reviews.
Monitoring	DDS and DHCS

Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 6	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims coded and paid in accordance with the reimbursement methodology in the approved State Plan. Numerator: Number of claims coded and paid in accordance with the reimbursement methodology in the approved State Plan Denominator: Total number of claims reviewed
Discovery Activity *(Source of Data & sample size)*	Audits of Regional Center. Stratified random sampling methodology is used.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS
Frequency	Biennially
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 6	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims coded and paid in accordance with the reimbursement methodology in the approved State Plan. Numerator: Number of claims coded and paid in accordance with the reimbursement methodology in the approved State Plan Denominator: Total number of claims reviewed
Discovery Activity *(Source of Data & sample size)*	Audits of vendors. Sample consists of randomly selected vendors with expenditures over $100,000 or upon referral
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS

Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 6	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims coded and paid in accordance with the reimbursement methodology in the approved State Plan. Numerator: Number of claims coded and paid in accordance with the reimbursement methodology in the approved State Plan Denominator: Total number of claims reviewed
Discovery Activity *(Source of Data & sample size)*	Audits of vendors. Sample consists of no less than 4% of the total number of vendors in specified services categories for which payments in the prior year were $100,000 or less
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Regional Centers
Frequency	Continuous and Ongoing.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS
Frequency *(of Analysis and Aggregation)*	

Requirement 6	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of claims paid in accordance with the consumer's authorized services. Numerator: Number of and percent of claims paid in accordance with consumer's authorized services Denominator: Total number of claims paid for participants were reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 6	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of funds identified in DDS fiscal audits for repayment to CMS within 12 months of final audit report. Numerator: Dollar amount of funds identified for repayment by DDS audits that were repaid to CMS within 12 months of final audit report Denominator: Total dollar amount identified for repayment to CMS
Discovery Activity	DDS fiscal audit recovery payments system

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 6	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(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.
Discovery Activity *(Source of Data & sample size)*	DDS Audits of regional center claims
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Continuously and ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 7(a)	The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of special incidents reported within required timeframes. Numerator: Number of special incidents reported within required timeframe Denominator: Number of special incidents reported
Discovery Activity *(Source of Data & sample size)*	Review of Special Incident Report database
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and Regional Centers
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and Regional Centers

Frequency *(of Analysis and Aggregation)*	As needed

Requirement 7(a)	**Identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of special incidents reported within required timeframes. Numerator: Number of special incidents reported within required timeframe Denominator: Number of special incidents reported
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and Regional Centers
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and Regional Centers
Frequency *(of Analysis and Aggregation)*	As needed

Requirement 7(a)	**Identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death**
Discovery	

	Discovery Evidence *(Performance Measure)*	Percent of incidents of abuse, neglect, exploitation, and unexplained death. Numerator: Number of consumers without reported incidents of abuse, neglect, exploitation, and unexplained death Denominator: Number of consumers on 1915(i)
	Discovery Activity *(Source of Data & sample size)*	Review of Special Incident Report database
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS/ Regional Centers
	Frequency	Continuously and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS/Regional Centers
	Frequency *(of Analysis and Aggregation)*	As needed

Requirement 7(a)	Identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of substantiated abuse, neglect, exploitation and unexplained death incidents that were referred to appropriate investigative entities (e.g., Law Enforcement, APS / CPS) for follow-up. Numerator: Number of substantiated abuse, neglect, exploitation and unexplained death incidents that were referred to appropriate investigative entities (e.g., Law Enforcement, APS / CPS) for follow-up

		Denominator: Number of substantiated abuse, neglect, exploitation and unexplained death incidents that required a referral to investigative entities (e.g., Law Enforcement, APS / CPS) for follow-up
	Discovery Activity *(Source of Data & sample size)*	Review of Special Incident Report database
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS/ Regional Centers
	Frequency	Continuously and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS/Regional Centers
	Frequency *(of Analysis and Aggregation)*	As needed

Requirement 7(b)	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.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of special incidents for which appropriate actions were taken. Numerator: Number of special incidents report that documented appropriate actions were taken Denominator: Number of incidents reported
Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 7(b)	**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.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of special incidents for which appropriate actions were taken. Numerator: Number of special incidents report that documented appropriate actions were taken Denominator: Number of incidents reported
Discovery Activity *(Source of Data & sample size)*	Review of special incident report data
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
Frequency	Continuously and ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
Frequency *(of Analysis and Aggregation)*	As needed.

Requirement 7(c)	**Ensures policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of instances in which state policies regarding restrictive intervention were followed. Numerator: Number of special incidents reported on the use of restrictive intervention in which state policies were followed Denominator: Number of special incidents reported on the use of restrictive interventions
Discovery Activity *(Source of Data & sample size)*	Review of special incident report data
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS, Regional Centers and independent risk management contractor
Frequency	Monthly and continuously ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	DDS, Regional Centers and independent risk management contractor

	timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	As needed.

	Requirement 7(d)	Establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.
Discovery		
	Discovery Evidence *(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
	Discovery Activity *(Source of Data & sample size)*	Record reviews conducted during biennial collaborative monitoring reviews. A random sample of IPPs will be reviewed to ensure all requirements are met. The sample size will represent a 95% confidence level with no more than a 5% margin of error.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDS and DHCS
	Frequency	Biennially
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DDS and DHCS
	Frequency *(of Analysis and Aggregation)*	As needed.

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The following describes State's quality management framework which starts with establishing clear expectations for performance (design), collecting and analyzing data to determine if the expectations are met (discovery), and finally, taking steps to correct deficiencies or improve processes and services (remediation and improvement).

Because the 1915(i) and 1915(c) Waiver are provided under the same service delivery system, a consolidated Quality Improvement Strategy (QIS) is appropriate for gathering data for some performance measures. For example, providers serve both populations and have the same mandates under both programs. Additionally, expenditures occur simultaneously, and fiscal oversight requirements are the same for both programs. Therefore, as indicated in the QIS tables above and referenced below, the quality reporting for some measurements in these areas will be the same for both the 1915(i) and 1915(c) Waiver while other measurements will reflect data specific to the 1915(i).

Service Plans or individual program plans (IPPs)

Performance expectations (design) in this area include:

- Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals.
- Service plans are reviewed at least annually and updated/revised when warranted by changes in the participant's needs.
- Services are delivered in the type, scope, amount, duration, and frequency in accordance with the service plan.
- Participants are afforded choice of qualified providers.

Data collected (discovery) to determine if expectations are met includes:

- DDS and DHCS conduct biennial monitoring reviews of a random sample of service recipient records to ensure service plans meet the expectations identified above. Monitoring will be completed over a two year period with reports produced after reviewing each geographical region (regional center). The statewide sample size will produce results with a 95% confidence level and no more than 5% margin of error. For example, with an estimated 40,000 recipients, the sample size would be 381. For this performance measure, the quality reports for the 1915(i) an1915(c) Waiver will reflect data exclusive to each program.
- The recipient survey portion of the recently revised Client Development and Evaluation Report (CDER) includes questions regarding the recipient's satisfaction with services.
- Annually, all recipients receive a statement of services and supports purchased by the regional center for the purpose of determining if services were delivered.

Steps to correct deficiencies or improve processes and services (remediation and improvement) include:

- Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DDS and DHCS. These plans are reviewed and approved by the State.

- The data from the monitoring reviews allows for identification of trends in a particular area (e.g. specific requirement or geographical area).
- If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review.
- Extra training and/or monitoring is provided if issues are not remediated or improvement is not shown.
- DDS' Quality Management Executive Committee (QMEC), also attended by DHCS management, meets at least semi-annually to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes.

Qualified Providers

Performance expectations (design) in this area include:

- DDS sets qualifications for providers through the regulatory process.
- Regional centers, through the vendorization process, verify that each provider meets the required qualifications (e.g. license, program design, staff qualifications) prior to services being rendered.
- DDS developed and funds the Direct Support Professional (DSP) Training program. This is a 70
- hour, competency-based program mandatory for all direct service staff working in licensed residential facilities. The program is based upon minimum core competencies staff must have to ensure the health and safety of individuals being served.
- DSS-CCLD is responsible for licensing community care facilities and establishes qualifications for providers. Administrators and applicants/licensees (sometimes one and the same) are required to take a 35-hour course from an approved trainer and pass a written test with a score of 70 percent or above to be a qualified administrator/licensee. There is a two-year re-certification requirement where they need to take an additional 35 hours of training. For each application, they must have a training plan in their facility operational plan for each of the new and continuing staff working in a community care facility.

Data collected (discovery) to determine if expectations are met includes:

Providers serve both 1915(i) and 1915(c) Waiver populations simultaneously and are required to meet the same requirements under both programs. Since providers don't exclusively serve one population or the other, it is not practical to separately collect data for PMs related to qualified providers. Therefore, the quality report for the 1915(i) and 1915(c) Waiver will include the same data.

- As part of the established biennial DDS/DHCS oversight activities, monitoring of service providers is conducted. Included in this review, service providers and direct support professionals are interviewed to determine that they are: knowledgeable regarding the care needs on the individual's plan of care for which they are responsible and that these services are being delivered; knowledgeable of and responsive to the health and safety/well-being needs of the consumer(s); and aware of their responsibilities for risk mitigation and reporting.
- An additional component of the established biennial DHCS/DDS monitoring is a review of settings to verify compliance with the HCBS settings requirements. DSS-CCLD monitors all licensed community care facilities to identify compliance issues. Facilities are reviewed to determine

compliance with regulations regarding provision of services, health and safety and provider qualifications.
- DSP training data is used to not only identify the success rate of staff taking the course, but also in what form (e.g. through classroom setting or challenge test) the course was taken and what areas (written test or skills check) caused failure for those who did not pass the course.
- Regional centers also monitor each licensed residential community care facility annually to verify or identify any issues with program implementation.
- Special incident report data allows for identification of trends with individual providers or types of providers.

Steps to correct deficiencies or improve processes and services (remediation and improvement) include:
- Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DDS and DHCS. These plans are reviewed and approved by the State.
- Any DSS-CCLD monitoring visit that results in a finding of non-compliance results in the development of a plan of correction. This requires follow-up by DSS-CCLD staff to verify that corrections were made.
- Issues identified during monitoring visits by regional centers may result in the need to develop a corrective action plan which details the issues identified and the steps needed to resolve the issues. The results of these reviews, as well as data from the special incident report system, are used to identify trends with individual or types of providers which may then result in focused or widespread training or other remediation measures.
- DDS' Quality Management Executive Committee (QMEC), also attended by DHCS management, meets at least semi-annually to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes. As an example, data from the special incident report system and analysis by the State's independent risk management contractor indicated that the second largest cause of unplanned hospitalizations was due to psychiatric admissions. In response, the QMEC approved the implementation of skill checks within challenge tests. The skill checks now require staff to demonstrate proficiency in the proper method of assisting individuals in the self-administration of medications.

SMA Programmatic Authority

Performance expectations (design) in this area include:
- DHCS and DDS conduct biennial monitoring reviews of a random sample of service recipient records to ensure service plans meet expectations.
- DHCS reviews and approves reports developed as a result of these monitoring visits.
- DHCS negotiates approval and amendment requests for the interagency agreement with DDS to ensure consistency with federal requirements.
- DHCS approves Section 1915(i) related policies and procedures that are developed by DDS to ensure consistency with federal requirements.
- DHCS participates, as necessary, in training to regional centers and providers regarding Section 1915(i) policies and procedures.
- DHCS, in conjunction with DDS and DSS-CCLD, holds quarterly meetings. The purpose of these meetings is to discuss issues applicable to licensed providers (community care facilities, day programs)

- DHCS participates in the DDS Quality Management Executive Committee. The purpose of these meetings is to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes.

Data collected (discovery) to determine if expectations are met includes:

- Results from the biennial monitoring reviews, conducted by DHCS and DDS, of a random sample of service recipient records to ensure service plans meet the expectations identified previously. For this performance measure, the quality reports for the 1915(i) and 1915(c) Waiver will reflect data exclusive to each program.
- Documentation of DHCS approval of monitoring or other required reports. Monitoring reports will also include approved plans submitted in response to findings by DHCS and DDS.
- Evidence of training provided as a result of findings from DHCS and DDS monitoring reviews.
- Minutes from meetings DHCS participates in documenting issues discussed and resolution activities planned.

Steps to correct deficiencies or improve processes and services (remediation and improvement) include:

- Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DHCS and DDS. These plans are reviewed and approved by the State.
- If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review.
- Extra training and/or monitoring is provided if issues are not remediated or improvement is not shown.

SMA Maintains Financial Accountability

Performance expectations (design) in this area include:

• DHCS reviews a sample of working papers prepared by DDS audit staff of the biennial fiscal audits. These fiscal audits are designed to wrap around the required annual independent CPA audit of each regional center.
• DHCS also annually reviews a sample of audits conducted of service providers.
• DHCS ensures recipients are eligible for Medi-Cal prior to claims being made.
• DHCS maintains invoice tracking, payment and reconciliation processes.

Data collected (discovery) to determine if expectations are met includes:

• Results of the audit reviews identify fiscal compliance issues. Electronic records and hard copy reports (as needed) are generated identifying recipients eligible for claiming.
• Tracking logs verify consistency between invoices, payments and funding authority.

Steps to correct deficiencies or improve processes and services (remediation and improvement) include:

• DHCS monitors and provides consultation as necessary regarding corrective actions and follow-up activities resulting from regional center and vendor audits. All issues identified in the audits include corrective action plans which may include policy revisions or repayments if necessary.
• DHCS works with DDS to resolve issues, if any, with identifying Medi-Cal eligibility of recipients.

Risk Mitigation

• Performance expectations (design) in this area include: Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals.
• DDS, through the regulatory process, has identified requirements for service providers and regional centers regarding reporting of special incidents. Providers must report all special incidents to the regional center within 24 hours. Subsequently, regional centers must report special incidents to DDS within two working days.
• DDS has implemented an automated special incident report (SIR) database which allows complex analysis of multiple factors to identify trends and provide feedback to regional centers.
• DDS provides data from the SIR database to the State's independent risk management contractor for further analysis.
• Regional centers must transmit SIRs, including the outcomes and preventative actions taken, to DDS as well as local licensing offices and investigative agencies as appropriate.
• Regional centers must develop and implement a risk management and prevention plan.
• Regional centers are responsible for using data from the SIR database for identifying trends that require follow-up.
• The State's independent risk management contractor is responsible for reviewing and analyzing DDS SIR data to identify statewide, regional and local trends requiring action. This includes defining indicators of problems requiring further inquiry. Additionally, the contractor performs ongoing review and analysis of the research and current literature with respect to preventing accidents, injuries and other adverse incidents.

Data collected (discovery) to determine if expectations are met includes:
• DDS and DHCS conduct biennial monitoring reviews of a random sample of service recipient records to ensure service plans address health and safety risk factors. For this performance measure, the quality reports for the 1915(i) and 1915(c) Waiver will reflect data exclusive to each program.
• Data from the SIR database includes recipient characteristics, risk factors, residence, responsible service provider and other relevant information. This data is updated daily and is available not only to DDS but also to regional centers for reviewing data of incidents in their area.
• While the SIR database collects information on all reported special incidents, the State also reviews a sample of consumer records during the monitoring reviews as a secondary quality assurance measure. If a significant difference in results is noted between the two data sources, the State will take appropriate steps further analyze the reason for the discrepancies. These steps may include but are not limited to a review of an expanded sample of consumer records and/or a review of data entry accuracy.
• The recipient survey portion of the CDER includes questions regarding the recipient's feelings of safety, availability of assistance if needed, and access to medical care.
• As part of the established biennial DDS/DHCS monitoring activities, information is gathered regarding the regional center's risk management system. Additionally, information is obtained reflecting how the regional center is organized to provide clinical expertise and monitoring of individuals with health issues, as well as any improvement in access to preventative health care resources.

Steps to correct deficiencies or improve processes and services (remediation and improvement) include:
• Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DDS and DHCS. These plans are reviewed and approved by the State.
• If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review.

• DDS uses data from the SIR database to identify compliance issues such as reporting timelines and notifications of other agencies if required. Contact is made with regional centers for correction. Training or technical assistance is provided if necessary.
• Utilizing results of data analysis from the SIR database, the State's risk management contractor conducts a variety of activities, including: develop and disseminate periodic reports and materials on best practices related to protecting and promoting the health, safety, and well-being of service recipients; provide on-site technical assistance to regional centers related to local risk management plans and activities; define indicators requiring further inquiry.
• The risk management contractor also develops and maintains a website, (www.ddssafety.net) for recipients and their families, providers, professionals, and regional center staff. This web site is dedicated to the dissemination of information on the prevention and mitigation of risk factors for persons with developmental disabilities. The site includes information from across the nation on current research and best practices and practical information directed towards improving health and safety.

2. Roles and Responsibilities

3. Frequency

4. Method for Evaluating Effectiveness of System Changes

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☒	HCBS Homemaker
☒	HCBS Home Health Aide
☒	HCBS Personal Care
☒	HCBS Adult Day Health
	Community Based Adult Services
☒	HCBS Habilitation
	Community Living Arrangement Services
	Day Services
	Behavioral Intervention Services
☒	HCBS Enhanced Habilitation
	Supported Employment
	Prevocational Services
☒	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)
	HCBS Personal Emergency Response System
	HCBS Vehicle Modification and Adaptation
	HCBS Speech, Hearing, and Language Services
	HCBS Dental Services

DESCRIPTION OF RATE METHODOLOGIES

The following rate methodologies are utilized by multiple providers of the services contained in this SPA. The methodologies are described in this section and are referenced under the applicable individual services. Consistent with Attachment 3.1-i, pages 2-3, qualified providers of 1915i SPA services submit claims to the regional center for services delivered to the beneficiary, pursuant to the individual program plan. The regional center reviews the claim (units of service, rate, etc), pays legitimate claims, and submits the claim of payment to Department of Developmental Services.

Rates Set pursuant to a Cost Statement Methodology – Prior to July 1, 2004, providers were reimbursed based on the permanent cost based rate which was developed using twelve consecutive months of actual allowable costs divided by the actual total consumer utilization (days or hours) for the same period. The permanent cost based rate must be within the applicable upper and lower limit rates established by the Department of Developmental Services.

Effective July 1, 2004, pursuant to state law, the upper and lower limit rates are no longer used. All new providers of services are reimbursed the fixed new vendor rate under the cost statement methodology. The rate schedule does not apply to providers vendored prior to July 1, 2004 because their rates were based on their costs. Vendors (vendored before and after July 1, 2004) have their rate adjusted when there are mandated service adjustments due to changes in, or additions to, existing statutes, laws, regulations or court decisions. Effective July 1, 2016, rates set through the Cost Statement Methodology 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. The rates are developed based on the service category, staff ratio, and are calculated as the mean of permanent cost-based rates for like providers established using the permanent costs-based rate methodology described above.

If 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 need, the Department of Development Services can grant prior written authorization to the regional center to reimburse the provider for the service based on the permanent cost based methodology described above using the most current cost data.

The following allowable costs used to calculate the permanent cost based rate:

- Direct costs for covered services: Includes unallocated payroll costs and other unallocated cost that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. For providers/facilities that are used for multiple purposes, the allowable costs are only those that are directly attributable to the provision of the medical services.

- Indirect costs: Determined by applying the cognizant agency specific approved indirect cost rate to its net direct costs or derived from provider's approved cost allocation plan. If a facility does not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and

related basis used to determine the allocated indirect costs must be in accordance with OMB Circular A-87 (if applicable), Medicare Cost Principle (42 CFR 413 and Medicare Provider Reimbursement Manual Part 1 and Part 2) and in compliance with Medicaid non-institutional reimbursement policy. For providers/facilities that are used for multiple purposes, the allowable costs are only those that are "directly attributable" to the professional component of providing the medical services. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed.

The applicable rate schedules are included in the descriptions of services below.

Usual and Customary Rate Methodology – Per California Code of Regulations (CCR), Title 17, Section 57210(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."

Department of Health Care Services (DHCS) Fee Schedules – Rates established by the single-state Medicaid agency for services reimbursable under the Medi-Cal program. Fee schedule rates are the maximum amount that can be paid for the service. For providers who have a usual and customary rate that is less than the fee schedule rates, the regional center shall pay the provider's usual and customary rate.

Median Rate Methodology - 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. This methodology is defined in California Welfare and Institutions Code section 4691.9(b)(a)(2) which stipulates that "no regional center may negotiate a rate with a new service provider, for services where rates are determined through a negotiation between the regional center and the provider, that is higher than the regional center's median rate for the same service code and unit of service, or the statewide median rate for the same service code and unit of service, whichever is lower. The unit of service designation must conform with an existing regional center designation or, if none exists, a designation used to calculate the statewide median rate for the same service." Effective July 1, 2016, rates set through the Median Rate Methodology 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 determined by the Department of Finance, in the case that the General Fund revenues and expenditures contain projected annual General Fund revenues that exceed projected annual General Fund expenditures in the 2021–22 and 2022–23 fiscal years by the sum total of General Fund moneys appropriated for all programs subject to suspension on December 31, 2021, then the implementation of this section shall not be suspended. More information about this bill can be found 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/wp-content/uploads/2019/12/SB81_LetterRC2020.pdf. (See page 5 of the document contained in the link).

While the law sets a cap on negotiated rates, the rate setting methodology for applicable services is one of negotiation between the regional center and prospective provider. Pursuant to law and the regional center's contracts with the Department of Developmental Services regional centers must maintain documentation on the process to determine, and the rationale for granting any negotiated rate (e.g. cost-statements), including consideration of the type of service and any education, experience and/or professional qualifications required to provide the service.

If the regional center demonstrates an increase to the median rate is necessary to protect a beneficiary's health and safety, the Department of Developmental Services can grant prior written authorization to the regional center to negotiate the reimbursement rate up to the actual cost of providing the service. In the process of establishing a negotiated rate, the regional center can require documentation such as cost statements or other financial documents to determine the actual cost to provide services. Additionally, providers would be required to submit education credentials or qualifications of the various classifications that would be providing services. This information would help inform the regional center when negotiating a rate with the provider, but not exceeding the median rate.

If the regional center demonstrates an increase to the median rate is necessary to protect a beneficiary's health and safety, the Department of Developmental Services can grant prior written authorization to the regional center to negotiate the reimbursement rate up to the actual cost of providing the service.

REIMBURSEMENT METHODOLOGY FOR HABILITATION – COMMUNITY LIVING ARRANGEMENT SERVICES

This service contains the following two subcomponents:

A. Licensed/Certified Residential Services – Providers in this subcategory are Foster Family Agency/Certified Family Home, Foster Family Home, Small Family Home, Group Home, Adult Residential Facility, Residential Facility for the Elderly, Out-of-State Residential Facility, Adult Residential Facility for Persons with Special Health Care Needs and Family Home Agency, Enhanced Behavioral Supports Homes, and In-Home Day Program Services.

There are five rate setting methodologies for all providers in this subcategory.

1) Alternative Residential Model (ARM) Methodology – The ARM methodology and monthly rates resulted from an analysis of actual costs of operating residential care facilities. The applicable cost components (see below) were analyzed to determine the statistical significance of the variation in costs among facilities by service type, facility size, and operation type. Based upon the results of this statistical analysis, the initial ARM rates were determined and became effective in 1987. Within this methodology 14 different service levels were established based upon the results of this cost analysis. Individual providers apply to be vendored at one of these service levels based upon the staffing ratios, service design, personnel qualifications and use of consultant services as described in their program design.

The following allowable costs were used in setting the ARM rates:

1. Direct costs for covered services: Includes unallocated payroll costs and other unallocated cost that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. For providers/facilities that are used for multiple purposes, the allowable costs are only those that are directly attributable to the provision of the medical services.

2. Indirect costs: Determined by applying the cognizant agency specific approved indirect cost rate to its net direct costs or derived from provider's approved cost allocation plan. If a facility does not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in accordance with OMB Circular A-87 (if applicable), Medicare Cost Principle (42 CFR 413 and Medicare Provider Reimbursement Manual Part 1 and Part 2) and in compliance with Medicaid non-institutional reimbursement policy. For facilities that are used for multiple purposes, the allowable costs are only those that are "directly attributable" to the professional component of providing the medical services. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed.

Rates may be updated by the legislature in various ways, including, but not limited to, the California Consumer Price Index, changes in staffing requirements (e.g. implementation of Direct Support Professional Training,) changes in minimum wage, and cost of living increases. Effective July 1, 2016, rates set through the ARM Methodology 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. The rate schedule, effective July 1, 2016 can be found at the following link: http://www.dds.ca.gov/Rates/docs/CCF_rate_July2016.pdf

Pursuant to Section 4681.5(b) of the Welfare and Institutions Code, effective July 1, 2016, the Department of Developmental Services established a rate schedule for residential community care facilities vendored to provide services to a maximum of four persons with developmental disabilities. The 4-bed or less rate schedule can be found at the following link: http://www.dds.ca.gov/Rates/docs/CCF_rate_July2016.pdf.

Effective May 1, 2019 – April 30, 2020, these rates were increased by 2.1 % for providers located in counties in which the average weekly wage is $900 or higher per the US Bureau of Labor Statistics data for the 4th quarter of 2017. These counties can be found here: https://www.bls.gov/regions/west/news-release/countyemploymentandwages_california.htm. Both List A and List B facilities received the same dollar amount increases per SB 81. However, List A facilities received the 2.1% increase effective 5/1/2019-4/30/2020, whereas List B did not. For example, effective 1/1/20 a 5-bed or more facility at the service level 4I on List A has a monthly rate of $7,912 and a 5-bed or more service level 4I facility on List B has a rate of $7,788. Both received the same dollar amount of $483 per the SB 81 rate increase because the SB 81 rate increase was calculated on the rate effective 12/31/19 less the amount of the 2.1% increase for List A. The difference in the level 4I List A and List B rates of $124 is attributed to the 2.1% rate increase. Upon approval, refer to the first paragraph on page 71 of this document for the link to rate-specific changes, the conditions under which

the payments may be extended, and information pursuant to SB 81. At the end of this period, the rates will revert to those in effect for providers elsewhere in the state.

The State will review rates for residential facilities set using the ARM methodology every three years to ensure that it complies with the statutory and regulatory requirements as specified under Section 1902(a)(30)(A). This will involve an analysis of the factors that have occurred since the ARM rates were initially developed, including changes in minimum wage and the general economy as measured through various indices such as Medicare Economic Index (MEI). The analysis will determine if the rates are consistent with the current economic conditions in the State while maintaining access to services. If this analysis reveals that the current rates may be excessive or insufficient when compared to the current economic conditions, the State will take steps to determine the appropriate reimbursement levels and update the fee schedule and State Plan. If the State determines that no rebasing is necessary, the State must submit documentation to CMS to support its decision.

2) Out-of-State Rate Methodology - This methodology is applicable for out-of-state residential providers. The rate paid is the established usual and customary rate for that service, paid by that State in the provision of that service to their own service population.

3) Median Rate Methodology – As described on pages 70-71, above. This methodology is used to determine the applicable monthly rate for Licensed/Certified Residential Service Providers. If a consumer's needs cannot be met within the ARM rate structure, the median rate methodology is used.

4) Enhanced Behavioral Supports Homes (Vendor-Operated) Rate Methodology - There are two components to the monthly rate for Enhanced Behavioral Supports 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 a negotiated amount based on cost estimates. The provider submits a facility budget to the regional center and the two determine a rate based upon where the facility is located (cost of living, lease, electricity, garbage, county minimum wage rates, the qualification of staff and consultants, and payroll costs).After detailed regional center review, that budget is then sent to the State department for further review and evaluation. The State department then analyzes the rates for each line item and compares it to the state average of other EBSHs. The provider is required to justify all costs and provide explanations of any estimated costs. The rate is effective upon approval from the state and providers are notified in writing by the vendoring regional center. As part of the certification process for Enhanced Behavioral Support Homes (EBSHs), the Department reviews the proposed facility component rate and supporting documentation for each EBSH and compares it to state averages to determine if the included costs are reasonable and economical. All rates must be approved by the Department director prior to the delivery of service at each EBSH. Rates are not reviewed annually, only as required and as agreed upon by the vendoring regional center. The state continues to receive the previous year's rate until the new rate is needed. Salaries are based upon the geographical area and the experience, education, and professional licensures held. Rate updates can happen due to cost changes in approved or active providers. For example, an increase can occur due to an increase in a vendor's lease or where another cost was higher than expected. The facility is required to show the Department their lease and contract. If the facility has an unexpected increase, they must justify the need for an increased budget and show that the cost is higher. Once the Department approves

the budget an approval letter is generated to the regional center and a copy is sent to the provider. The regional center may submit a new DS 6023 budget to the Department for review and approval of any updates to the rate. When a rate is updated, the new rate is effective once the state department approves. A letter is sent out to the facility approving the new rate. The initial rate is effective upon the first consumer's admission into the facility.

Maximum and minimum rates are set pursuant to Title 17 Sec. 59072 (a)(2) & (c), which states the rate limit may not exceed the rate limit determined by the department and administrative costs may not exceed 15%. It takes from 1-3 months to set a facility rate depending on the review process. The department may take up to three months due to additional documentation requests to ensure the accuracy of the rate requested.

The EBSH rate methodology is used when a consumer requires enhanced behavioral supports, staffing, and supervision in a homelike setting, such as additional staffing supervision, facility characteristics, or other services and supports to address a consumer's challenging behaviors, which are beyond what is typically available in other community facilities licensed as an adult residential facility or a group home to serve individuals in a community setting rather than an institution, as defined in Welfare and Institutions Code section 4684.80.

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. The individual rate is determined by the Individual Program Plan (IPP) process. The providers are invited to a meeting along with a regional center representative to review consumer needs and a rate is set and agreed upon at the meeting. As part of the IPP review process, it is the responsibility of the regional center to ensure that services authorized meet the needs of the consumer. The rate is reviewed within 60 days of initial placement, and at least annually thereafter. The facility submits a completed Department form DS 6024 to the regional center within 30 days, for review and written approval. The provider receives a copy of the new rate at the time of the IPP meeting when it is initially determined and notified by the regional center when that rate is confirmed. The effective date is determined at the time of the IPP and is typically in effect either immediately or at the time the DS 6024 form is signed. The DS 6024 form can be found on the CA DDS website here: https://www.dds.ca.gov/transparency/dds-forms/

The individualized services and supports component described above includes direct care and behavioral support staff with identifiable experience and qualifications as is referenced in the state plan. Providers receive payment via the identified rate methodology described above for services provided as part of the individualized services and supports component. Any provider delivering services through a bundle will be paid through that bundle's payment rate and cannot bill separately; Medicaid providers delivering separate services outside of the bundle may bill for those separate services in accordance with the state's Medicaid billing procedures.

Within the individualized services and supports component, at least one (1) service must be provided by identified direct care staff described above to bill according to the individualized services and supports rate methodology.
The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services, as assured in the Administration and Operation Section in Attachment 3.1-I of the state plan.
The state ensures appropriate billing through its audit process, as well as the remission of payment to CMS in the case of overpayments for (1) services that were not provided in accordance with the

regional center's contract or authorization with the provider, or with applicable state laws or regulations, or (2) the rate paid is based on inaccurate data submitted by the provider on a provider cost statement.

Attachment 3.1-i authorizes the following covered services for provision by EBSHs: Habilitation-Community Living Arrangements.

5) Enhanced Behavioral Supports Homes (State-Operated) Rate Methodology-
Interim rate: The allowable costs used to calculate the interim rate include lease, facility maintenance, repairs, cable/internet, and services and supports, which include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports from the previous fiscal year. All cost information is collected on a monthly basis through the state-wide accounting system. The state pays for interim costs on a monthly basis. Providers are state employees and are paid their salaries monthly. The interim rate is reconciled as described below. For new homes in which the facility-specific first-year costs are not available, the state will use an estimated average of costs based on similar homes as the estimate for the interim rate. After the first year of operation, the same reconciliation process is followed as described below.

Reconciliation: The state reviews submitted claims for the past fiscal year and determines the facility-specific average cost of claims for that year, based on the same cost components described above for the interim rate. After the facility-specific cost rates are established, claims are reconciled at the true cost of delivering the service. Costs are reimbursed if the final rate is higher than the interim rate or recouped if the final rate is lower than the interim rate. Final reconciliation will occur prior to the close of the claiming period (no more than 24 months after the service is provided) which follows the end of the fiscal year. The state is responsible for reimbursing CMS for all FFP overpayments identified.

Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation an apportioning those expenses to the Medicaid program, except as expressly modified below.

B. Supported Living Services provided in a Consumer's own Home (Non-Licensed/Certified) Supported Living Services providers are in this subcategory. Maximum hourly rates for these providers are determined using the median rate methodology, as described on pages 70-71 above.

REIMBURSEMENT METHODOLOGY FOR HABILITATION – DAY SERVICES

This service is comprised of the following three subcomponents:

A. Community-Based Day Services – There are two rate setting methodologies for providers in this subcategory.

1) Rates Set pursuant to a Cost Statement Methodology – As described on page 69, above. This methodology is applicable to the following providers (unit of service in parentheses): Activity Center (daily), Adult Development Center (daily), Behavior Management Program (daily), Independent Living Program (hourly), and Social Recreation Program (hourly). Effective May 1, 2019 – April 30, 2020, these rates were increased by 2.1% for providers located in counties in which

the average weekly wage is $900 or higher per the US Bureau of Labor Statistics data for the 4th quarter of 2017. These counties can be found here: https://www.bls.gov/regions/west/news-release/countyemploymentandwages_california.htm. Upon approval, these rates are available at the following link: https://www.dds.ca.gov/wp-content/uploads/2019/12/CBDP_IHRA_Rates.pdf. At the end of this period, the rates will revert to those in effect for providers elsewhere in the state. Refer to the first paragraph on page 71 of this document for a link to rate-specific changes, the conditions under which the payments may be extended, and information pursuant to SB 81.

2) Median Rate Methodology – As described on pages 70-71, above. This methodology is used to determine the applicable daily rate for Creative Art Program, Community Integration Training Program and Community Activities Support Services providers. This methodology is also used to determine the applicable hourly rate for Adaptive Skills Trainer, Socialization Training Program, Personal Assistance and Independent Living Specialist providers.

B. Therapeutic/Activity-Based Day Services – The providers in this subcategory are Specialized Recreation Therapy, Special Olympics, Sports Club, Art Therapist, Dance Therapist, Music Therapist and Recreational Therapist. The units of service for all providers are daily, with the exception of Sports Club providers, who have a monthly rate. There are two rate setting methodologies for providers in this subcategory.

1) Usual and Customary Rate Methodology – As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above, with the exception that the 2020 rate increase does not apply.

C. Mobility Related Day Services – The providers in this subcategory are Driver Trainer, Mobility Training Services Agency and Mobility Training Services Specialist. There are two rate setting methodologies for providers in this subcategory. There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.

1) Usual and Customary Rate Methodology - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above.

REIMBURSEMENT METHODOLOGY FOR HABILITATION, PREVENTIVE SERVICES (BEHAVIORAL HEALTH TREATMENT [1]) AND BEHAVIORAL INTERVENTION SERVICES

This service is comprised of the following two subcomponents:

A. Non-Facility-Based Behavior Intervention Services– Providers and services in this subcategory are Behavior Analysts, Associate Behavior Analysts, Behavior Management Assistants, Behavior Management Intervention Training, Parent Support Services, Individual/Family Training Providers, Family Counselors, and

[1] Please refer to Item l3(c) and Supplement 6 to Attachment 3.1-A, page 1, of the State Plan Amendment

Behavioral Technicians, Educational Psychologists, Clinical Social Workers, and Professional Clinical Counselors. There are two rate setting methodologies to determine the hourly rates for all providers in this subcategory (except psychiatrists, physicians and surgeons, physical therapists, occupational therapists, psychologists, Marriage and Family Therapists (MFT), speech pathologists, and audiologists -see DHCS Fee Schedule below).

1) Usual and Customary Rate Methodology - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above.

3) DHCS Fee Schedules - The fee schedule rates for Non-Facility-Based Behavior Intervention Services were set as of July 15, 2016 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx

B. Crisis Intervention Facility – The following five methodologies apply to determine the daily rates for these providers;

1) Usual and Customary Rate Methodology - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above, with the exception that the 2020 rate increase does not apply.

3) Community Crisis Homes (Vendor-Operated) Rate Methodology - There are three components to the monthly rate for Community Crisis Homes:
   a) *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.
   b) *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, and
   c) *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.

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. All claims for CCHs are validated in the waiver billing system to ensure the cost of room and board is excluded from the claim prior to claiming FFP. In California, the cost of room and board is less than or equivalent to the Supplemental Security Income/State Supplement Payment (SSI/SSP) amount. Rates for providers of CCHs include the amount for room and board and an additional amount for the provision of support services. Prior to claiming FFP, the amount of the claim is compared to the provider's rate to ensure that only the amount in excess of the SSI/SSP amount is claimed for FFP. For example, if a provider's rate is $2,000/month, and

the SSI/SSP amount equals $960, the Waiver billing system will not process claims that are more than $1,040 ($2,000 - $960 = $1,040).

4) Community Crisis Homes (State-Operated) Rate Methodology –

Interim rate: The allowable costs used to calculate the interim rate include lease, facility maintenance, repairs, cable/internet, and services and supports, which include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports from the previous fiscal year. All cost information is collected on a monthly basis through the state-wide accounting system. The state pays for interim costs on a monthly basis. Providers are state employees and are paid their salaries monthly. The interim rate is reconciled as described below. For new homes in which the facility-specific first-year costs are not available, the state will use an estimated average of costs based on similar homes to estimate the interim rate. After the first year of operation, the same reconciliation process is followed as described below.

Reconciliation: The state reviews submitted claims for the past fiscal year and determines the facility-specific average cost of claims for that year, based on the same components described above for the interim rate. After facility specific cost rates are established, claims are reconciled at the true cost of delivering the service. Costs are reimbursed if the final rate is higher than the interim rate or recouped if the final rate is lower than the interim rate. Final reconciliation will occur prior to the close of the claiming period (no more than 24 months after the claim is filed) which follows the end of the fiscal year. The state is responsible for reimbursing CMS for all FFP payments for all overpayments identified.

Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning these expenses to the Medicaid program, except as expressly modified below.

5) Mobile Crisis Team (State-Operated) Rate Methodology –

Interim rate: The allowable costs used to calculate the interim rate include services and supports, which include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports, in addition to travel costs, from the previous fiscal year. All cost information is collected on a monthly basis through the state-wide accounting system. The state pays for interim costs on a monthly basis. Providers are state employees and are paid their salaries monthly. The interim rate is reconciled as described below.

Reconciliation: The state reviews submitted claims for the past fiscal year and determines the average cost of claims for that year, based on the same components described above for the interim rate. After the cost rates are established, claims are reconciled at the true cost of delivering the service. Costs are reimbursed if the final rate is higher than the interim rate or recouped if the final rate is lower than the interim rate. Final reconciliation will occur prior to the close of the claiming period (no more than 24 months after the service is provided), which follows the end of the fiscal year. The state is responsible for reimbursing CMS for all FFP payments for all overpayments identified.

Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which

establish principles and standards for determining allowable costs and the methodology for allocation and apportioning these expenses to the Medicaid program, except as expressly modified below.

REIMBURSEMENT METHODOLOGY FOR RESPITE CARE

There are five rate setting methodologies for Respite Services. The applicable methodology is based on whether the service is provided by an agency, individual provider or facility, type of facility, and service design.

1) Rates Set pursuant to a Cost Statement Methodology – As described on page 69, above. This methodology is used to determine the hourly rate for In-home Respite Agencies. Effective May 1, 2019 – April 30, 2020, these rates were increased by 2.1% for providers located in counties in which the average weekly wage is $900 or higher per the US Bureau of Labor Statistics data for the 4th quarter of 2017. These counties can be found in the following link: https://www.bls.gov/regions/west/news-release/countyemploymentandwages_california.htm. These rates are available at the following link: https://www.dds.ca.gov/wp-content/uploads/2019/12/CBDP_IHRA_Rates.pdf. At the end of this period, the rates will revert to those in effect for providers elsewhere in the state. Refer to the first paragraph on page 71 of this document for a link to rate-specific changes, the conditions under which the payments may be extended, and information pursuant to SB 81.

2) Rates set in State Regulation – This rate applies to individual respite providers. Per Title 17 CCR, Section 57332(c)(3), the rate for this service is $15.23 per hour. This rate is based on the current California minimum wage of $10.00 per hour, effective January 1, 2016, plus $1.17 differential (retention incentive), plus mandated employer costs of 17.28%; a 5% rate increase for respite services per Assembly Bill (AB) X2-1, effective July 1, 2016; and an 11.25% rate increase for enhancing wages and benefits for staff who spend 75% of their time providing direct services to consumers per AB X2-1, effective July 1, 2016. Refer to the first paragraph on page 71 of this document for a link to rate-specific changes, the conditions under which the payments may be extended, and information pursuant to SB 81.

3) ARM Methodology - As described on pages 71-73 above. This methodology is applicable to respite facilities that also have rates established with this methodology for "Habilitation-Community Living Assistance Services." The daily respite rate is 1/21 of the established monthly ARM rate. This includes Foster Family Agency/Certified Family Home, Foster Family Home, Small Family Home, Group Home, Adult Residential Facility, Residential Care Facility for the Elderly, Adult Residential Facility for Persons with Special Health Care Needs and Family Home Agency. If the facility does not have rate for "Habilitation-Community Living Assistance Services" using the ARM methodology, then rates are set using #5 below.

4) Usual and Customary Rate Methodology - As described on page 70, above. This methodology is applicable for the following providers (unit of service in parentheses); Adult Day Care Facility (daily), Camping Services (daily) providers. If the provider does not have a usual and customary rate, then rates are set using #5 below.

5) Median Rate Methodology - As described on pages 70-71, above.

REIMBURSEMENT METHODOLOGY FOR ENHANCHED HABILITATION – SUPPORTED EMPLOYMENT (INDIVIDUAL)

There are two rate setting methodologies for this service:

1) Supported employment rates for all providers are set in State statute [Welfare and Institutions Code Section 4860(a)(1)] at $36.57 per job coach hour, effective July 1, 2016. The rate schedule, effective July 1, 2016, can be found at the following link: https://www.dds.ca.gov/wp-content/uploads/2019/12/WAP_SEP_Rates.pdf

   Refer to the first paragraph on page 71 of this document for a link to rate-specific changes, the conditions under which the payments may be extended, and information pursuant to SB 81.

2) Incentive payments will be paid to service providers as referenced in WIC 4870(d). Incentive payments include 1) A one-time payment of $1,000 made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days. 2) An additional one-time payment of $1,250 made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $1,500 made to a provider when an individual has been employed consecutively for one year.

REIMBURSEMENT METHODOLOGY FOR ENHANCED HABILITATION – PREVOCATIONAL SERVICES

There are three rate setting methodologies for this service:

1) Daily rates for Work Activity Program providers are set using the cost statement methodology, as described on page 69. The Work Activity Program rate schedule can be found at the following link. The rate schedule is effective July 1, 2016 https://www.dds.ca.gov/wp-content/uploads/2019/12/WAP_SEP_Rates.pdf

2) Rates for Supported Employment Group providers are set in State statute [Welfare and Institutions Code Section 4860(a)(1)]. The rate schedule, effective January 1, 2020, can be found at the following link: https://www.dds.ca.gov/wp-content/uploads/2019/12/WAP_SEP_Rates.pdf

   Refer to the first paragraph on page 71 of this document for a link to rate-specific changes, the conditions under which the payments may be extended, and information pursuant to SB 81.

3) Incentive payments will be paid to service providers as referenced in WIC 4870(d). Incentive payments include 1) A one-time payment of $1,000 made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days. 2) An additional one-time payment of $1,250 made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $1,500 made to a provider when an individual has been employed consecutively for one year.

REIMBURSEMENT METHODOLOGY FOR HOMEMAKER SERVICES

There are two rate methodologies to set hourly rates for Homemaker services provided by either an agency or individual.

1) Usual and Customary Rate Methodology - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above.

REIMBURSEMENT METHODOLOGY FOR HOME HEALTH AIDE SERVICES

DHCS Fee Schedules - As described on page 70, above. The fee schedule rates for Home Health Aide Services were set as of July 15, 2016 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx

REIMBURSEMENT METHODOLOGY FOR COMMUNITY BASED ADULT SERVICES

DHCS Fee Schedules - As described on page 70, above. Specific daily rates can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx

REIMBURSEMENT METHODOLOGY FOR PERSONAL EMERGENCY RESPONSE SYSTEMS

There are two methodologies to determine the monthly rate for this service.

1) Usual and Customary Rate methodology - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR VEHICLE MODIFICATION AND ADAPTATION

The per modification rate for vehicle modifications is determined utilizing the usual and customary rate methodology, as described on page 70, above.

REIMBURSEMENT METHODOLOGY FOR SPEECH, HEARING LANGUAGE SERVICES

There are two rate setting methodologies for this service:

1) DHCS Fee Schedules - As described on page 70, above. The fee schedule rates for Speech, Hearing Language Services were set as of July 15, 2016 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/RatesHome.aspx

2) Median Rate Methodology – the median rate (as defined previously) may be used if the provider has at least one year experience working with persons with developmental disabilities, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR DENTAL SERVICES

There are two rate setting methodologies for this service:

1) DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective July 15, 2016 can be found at the following link: https://files.medi-cal.ca.gov/rates/RatesHome.aspx

2) Median Rate Methodology – the median rate (as defined previously) may be used if the provider has at least one year experience working with persons with developmental disabilities, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR OPTOMETRIC/OPTICIAN SERVICES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective July 15, 2016 can be found at the following link: https://files.medi-cal.ca.gov/rates/RatesHome.aspx

REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION LENSES AND FRAMES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective July 15, 2016 can be found at the following link: https://files.medi-cal.ca.gov/rates/RatesHome.aspx

REIMBURSEMENT METHODOLOGY FOR PSYCHOLOGY SERVICES

There are two rate setting methodologies for this service:

1) DHCS Fee Schedules - As described on page 70, above. The fee schedule rates for Psychology Services were set as of July 15, 2016 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/RatesHome.aspx

2) Median Rate Methodology – the median rate (as defined previously) may be used if the provider has at least one year experience working with persons with developmental disabilities, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR CHORE SERVICES

Usual and Customary Rate Methodology - As described on page 70, above.

REIMBURSEMENT METHODOLOGY FOR COMMUNICATION AIDES

There are two methodologies to determine the monthly rate for this service.

1) Usual and Customary Rate Methodology - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Usual and Customary Rate Methodology - As described on page 70, above.

REIMBURSEMENT METHODOLOGY FOR NON-MEDICAL TRANSPORTATION

There are three methodologies to determine the monthly rate for this service (except individual transportation providers – see Rate based on Regional Center Employee Travel Reimbursement below).

1) Usual and Customary Rate Methodology - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) Median Rate Methodology - As described on pages 70-71, above.

3) Rate based on Regional Center Employee Travel Reimbursement – The maximum rate paid to an individual transportation provider is established as the travel rate paid by the regional center to its own employees. This rate is used only for services provided by an individual transportation provider.

REIMBURSEMENT METHODOLOGY FOR NUTRITIONAL CONSULTATION

Usual and Customary Rate Methodology - As described on page 70, above.

REIMBURSEMENT METHODOLOGY FOR SKILLED NURSING

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective July 15, 2016 can be found at the following link: https://files.medi-cal.ca.gov/rates/RatesHome.aspx

REIMBURSEMENT METHODOLOGY FOR SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective July 15, 2016 can be found at the following link: https://files.medi-cal.ca.gov/rates/RatesHome.aspx

REIMBURSEMENT METHODOLOGY FOR TRANSITION/SET-UP EXPENSES

Usual and Customary Rate Methodology - As described on page 70, above.

REIMBURSEMENT METHODOLOGY FOR COMMUNITY-BASED TRAINING SERVICES

The maximum rate for this service is set in State statute [Welfare and Institutions Code Section 4688.21(c)(7)] at $14.99 per hour. Refer to the first paragraph on page 71 of this document for a link to rate-specific changes, the conditions under which the payments may be extended, and information pursuant to SB 81.

REIMBURSEMENT METHODOLOGY FOR FINANCIAL MANAGEMENT SERVICES

Rates for FMS are set in State regulation, Title 17, CCR, Section 58888(b) as follows:

If the FMS functions as a fiscal/employer agent, the rate is based on the number of participant-directed services used by the consumer:

- (A) A rate not to exceed a maximum of $45.88 per consumer per month for one participant-directed service; or
- (B) A rate not to exceed a maximum of $71.73 per consumer per month for two or three participant-directed services; or
- (C) A rate not to exceed a maximum of $96.86 per consumer per month for four or more participant-directed services.

If the FMS functions as a co-employer, the rate is not to exceed a maximum of $96.86 per consumer per month for one to four co-employer services.

REIMBURSEMENT METHODOLOGY FOR INTENSIVE TRANSITION SERVICES

Effective July 1, 2020, the rate for Intensive Transition service and supports will be established using the average cost of services rendered to Medi-Cal beneficiaries in state fiscal year 2019-20. The costs used to calculate the rate are salaries, wages, payroll taxes, and benefits of direct care staff providing Intensive Transition services and supports, in addition to direct care staff travel and operating costs (other indirect costs such as communications, equipment, and program supplies) needed to support a consumer during a transition. The costs will be drawn from actual expenditures as reported by providers of ITS services. Upon regional center approval, the providers of this service will be informed of the rate in writing and the rate will be available at the following link: https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendor-rates/ This final rate will be used for all ITS vendors including any new vendors that get vendored after 2019-20. The costs in state fiscal year 2019-20, comprised of a 12-month period of time, will be used to inform the permanent, single statewide rate of all ITS vendors in the following state fiscal year.

Components of this service are assessments; substance use and recovery treatment, anger management, self-advocacy, medication management, health and dietary education, sex education, fostering healthy relationships, behavioral support and modification training for the individual, outpatient therapy, co-occurring disorders integrated treatment, and transition planning. This service is paid as a monthly unit. Any provider delivering services through ITS will be billed and paid through the ITS agency and not individually. If a provider delivers services outside of the ITS services agency purview, that provider should bill such services separately. At least one of the services included in ITS must be provided per month for the ITS
agency to bill for payment. The state conducts yearly monitoring of the IPP to ensure services are needed and that also includes a verification of rates paid in accordance with state approved payment methodology. The IPP process includes initial and ongoing review on no later than an annual basis to ensure that services are provided efficiently and continue to meet the individual need of the consumer. Additionally, service-specific plans from the provider that demonstrate the frequency and manner in which services are actually provided are reviewed on no less than a quarterly basis.

Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for

allocation an apportioning those expenses to the Medicaid program, except as expressly modified below.

The state assures that it will only begin seeking Federal Financial Participation for ITS once an individual is eligible to receive the service.

REIMBURSEMENT METHODOLOGY FOR HOUSING ACCESS SERVICES

The rate for Housing Access Service is determined utilizing the U&C rate methodology as previously defined.

REIMBURSEMENT METHODOLOGY FOR FAMILY SUPPORT SERVICES

There are two rate setting methodologies for this service. If the provider does not have a "usual and customary," then the maximum rate is set using the median rate setting methodology. Usual and customary and median rates are defined previously, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR OCCUPATIONAL THERAPY

There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.

1) DHCS Fee Schedules - As described on page 70, above. The fee schedule rates for Occupational Therapy Services were set as of July 15, 2016 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/RatesHome.aspx.

2) Median Rate Methodology – As described on pages 70-71, above, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR PHYSICAL THERAPY

There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.

1) DHCS Fee Schedules - As described on page 70, above. The fee schedule rates for Physical Therapy Services were set as of July 15, 2016 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/RatesHome.aspx.

2) Median Rate Methodology – As described on pages 70-71, above, with the exception that the 2020 rate increase does not apply.

REIMBURSEMENT METHODOLOGY FOR FAMILY/ CONSUMER TRAINING

The median rate methodology, as described on pages 70-71 above, is used to determine the hourly rates for providers in this subcategory, with the exception that the 2020 rate increase does not apply.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☒ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.