

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

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The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

### 1. Major Changes

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

1. Changing case managers' face-to-face reassessment intervals from 90 days to 180 days, with at least a monthly face-to-face contact.
2. Allowing for all primary care providers, and not just the primary physician, to sign the HIV/AIDS diagnosis certificate of eligibility.
3. Per new CMS requirements, requiring better documentation of participant's involvement in service plan development and choice of service providers.
4. Spousal impoverishment information has been applied.
5. Completed new section regarding State Transition Plan activities.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

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- A. The **State of California** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)**
- C. **Type of Request: renewal**

**Requested Approval Period:** (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

- 3 years  5 years

**Original Base Waiver Number: CA.0183**

**Draft ID: CA.007.04.00**

**D. Type of Waiver** *(select only one):*Regular Waiver **E. Proposed Effective Date:** *(mm/dd/yy)*

01/01/17

**1. Request Information (2 of 3)**

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

 **Hospital**

Select applicable level of care

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

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

 **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160** **Nursing Facility**

Select applicable level of care

 **Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155**

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

 **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140** **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

**1. Request Information (3 of 3)**

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

Select one:

 **Not applicable** **Applicable**

Check the applicable authority or authorities:

 **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I** **Waiver(s) authorized under §1915(b) of the Act.**

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

Specify the §1915(b) authorities under which this program operates *(check each that applies):* **§1915(b)(1) (mandated enrollment to managed care)** **§1915(b)(2) (central broker)** **§1915(b)(3) (employ cost savings to furnish additional services)**

- §1915(b)(4) (selective contracting/limit number of providers)**
- A program operated under §1932(a) of the Act.**  
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- A program authorized under §1915(i) of the Act.**
- A program authorized under §1915(j) of the Act.**
- A program authorized under §1115 of the Act.**  
Specify the program:

#### H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

## 2. Brief Waiver Description

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

The purpose of the HIV/AIDS Medicaid Home and Community-Based Services Waiver (herein referred to as the AIDS Waiver) is to provide enhanced case management and direct care services as an alternative to nursing facility care or hospitalization. Case management incorporates a collaborative interdisciplinary team approach consisting of a nurse and social work case manager, who work with the participant, his/her primary care provider, family, caregivers, and other service providers to determine and deliver needed services to participants who choose to live in a home setting rather than in an institution.

The goals of the program are to:

- Enroll individuals into home and community-based services who have a written diagnosis of HIV/AIDS, a health status stable enough to make home care appropriate, are eligible for Medi-Cal on date of enrollment and each month thereafter, and have been certified by a Registered Nurse (RN) to meet the Nursing Facility Level of Care (NF-LOC) as defined by Title 22, California Code of Regulations, Sections 51334 and 51335 prior to enrollment and every 180 days thereafter;
- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care;
- Increase coordination among service providers and eliminate duplication of services;
- To consider enrollment in the program as time limited. As participant's medical and psychosocial status improves, the participant will be assisted in transitioning to more appropriate programs, freeing the AIDS Waiver resources for those in most need; and,
- Enhance utilization of the program by underserved populations.

The objectives of case management within the AIDS Waiver are:

- To coordinate efficient use of community resources in a cost effective, high quality manner acceptable to the participant;
- To foster continuity of services throughout the continuum of care;
- To promote understanding by the participant and/or legal representative, family, and caregivers of the HIV disease process and the use of health promotion practices;
- To decrease the transmission of HIV through education/harm reduction techniques;
- To maintain quality health care along the continuum of illness;
- To decrease fragmentation of care; and
- To provide services through culturally and linguistically appropriate services.

Services for AIDS Waiver participants include:

- Attendant Care
- Homemaker Services
- Skilled Nursing-RN/LVN
- Nutritional Counseling
- Home-Delivered Meals

- Specialized Medical Equipment/Medical Supplies
- Minor Physical Adaptions to the Home
- Nutritional Supplements
- Non-Emergency Medical Transportation
- Nurse and Social Work Case Management
- Psychotherapy
- Medi-Cal Supplement for Infants and Children in Foster Care

The organizational structure includes the following:

The Department of Health Care Services (DHCS) serves as liaison to the federal Centers for Medicare and Medicaid Services (CMS) in fulfilling its role as California's Single State Medicaid Agency (SSMA). DHCS' Long-Term Care Division (LTCD) oversees the monitoring and oversight of the implementation and administration of the Waiver.

DHCS delegates administration of the programmatic components of the AIDS Waiver to the California Department of Public Health (CDPH) through an Interagency Agreement. CDPH/Office of AIDS (CDPH/OA) provides program oversight and monitoring, and reports to DHCS' LTCD.

CDPH/OA contracts directly with local agencies statewide to deliver the AIDS Waiver program services.

Local AIDS Waiver Agencies are responsible for:

- Conducting community outreach to access populations and/or groups in the community disproportionately affected by HIV/AIDS;
- Carrying out eligibility screening, intake and enrollment, assist with institutional discharge to ensure the transition of qualified individuals into the AIDS Waiver program;
- Performing initial and ongoing assessments of participant's physical, psychosocial, environmental, financial, and functional status;
- Collecting and reporting instances of abuse, neglect, and exploitation affecting the participant and informing participants on how to report to their case manager(s) or self-report instances of abuse, neglect, and exploitation;
- Identifying and proposing resolution of problems in utilization and delivery of participant services;
- Developing, implementing, monitoring, and modifying Participant Centered Service Plan (PCSP) through an interdisciplinary team process in collaboration with the participant and his/her caregivers;
- Incorporating participant preferences and desires regarding services and service providers into the PCSP;
- Coordinating the provision of AIDS Waiver services to the participant;
- Transitioning participant to less intensive case management when health and functional status improves and stabilizes;
- Linking participants with the most appropriate resources and advocating for the best interests of the participants; and
- Conducting continuous quality improvement and assurance activities to ensure compliance with all AIDS Waiver requirements and high quality service delivery.

### 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

#### 4. Waiver(s) Requested

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

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

- Not Applicable**
- No**
- Yes**

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

- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewidness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- Limited Implementation of Participant-Direction.** A waiver of statewidness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

#### 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:

Public input is secured as follows:

- Email notification to all Project Directors soliciting input into the development of the AIDS Waiver.
- The CDPH/OA website has a link to the DHCS website specific to the AIDS Waiver, which includes a link for public comment or suggestions.
- AIDS Waiver renewal input is gathered from Project Directors, program staff, and stakeholders, and is ongoing during the AIDS Waiver renewal period until final submission to CMS.
- California Planning Group (CPG):

The mission of the CPG is to provide community perspectives, advice, and recommendations to CDPH/OA in the planning, development, and allocation of resources for a comprehensive, participant-centered continuum of prevention, care, treatment, and other support services. Through CPG, AIDS Waiver renewal information will be provided to stakeholders.

Members include HIV care and prevention service providers, researchers, administrators, and persons living with HIV – all representing diverse communities throughout the State, and acting on behalf of all HIV-infected and affected communities in California. The HIV Care Branch Chief attends meetings of the CPG, provides program updates and receives feedback from members.

- Ryan White Part A Planning Councils (PCs):

Part A grantees are required by HRSA to have PCs who represent consumers, providers, advocates, etc. The PCs have authority over the Part A allocations. The planning council alone decides what services are priorities for funding and how much funding should be provided for each service category. Meetings are held either monthly or quarterly and are open to the public. The public is encouraged to attend and public comment is part of each council's agenda.

PCs will be updated on the AIDS Waiver renewal and public comment process by CDPH/OA staff.

- California's Integrated HIV Surveillance, Prevention, and Care Plan (Integrated Plan):

The Integrated Plan is a mechanism for addressing key HIV/AIDS care issues and enhancing coordination across Ryan White CARE Act (RWCA) programs and parts DPH/OA is responsible for coordinating the Integrated Plan with input from all RWCA parts and grantees. The development of the Integrated Plan is a collaborative process that includes representations of all parts of the RWCA as well as representatives of other HIV care, treatment and prevention programs throughout California. When developing or modifying this AIDS Waiver, particular attention is paid to the Integrated Plan section on the need and provision of various services.

- Public Input Activities Conducted by AIDS Waiver Agencies

AIDS Waiver Agencies' staff will notify their participants of the public comment opportunities including how to provide comment both electronically and non-electronically.

- Participant Satisfaction Surveys:

AIDS Waiver Agencies conduct annual participant satisfaction surveys with AIDS Waiver participants to solicit input regarding AIDS Waiver services. AIDS Waiver Agencies send survey summaries to CDPH/OA for review. CDPH/OA reviews and analyzes the summaries and provides technical assistance and follow up as indicated. These surveys are used to inform changes to the AIDS Waiver.

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is

provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

## 7. Contact Person(s)

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

**Last Name:**

Schupp

**First Name:**

Rebecca

**Title:**

Chief, Long-Term Care Division

**Agency:**

Department of Health Care Services

**Address:**

1501 Capitol Avenue

**Address 2:**

P.O. Box 997413, MS 0000

**City:**

Sacramento

**State:**

California

**Zip:**

95899-7413

**Phone:**

(916) 319-9247 Ext:   TTY

**Fax:**

(916) 552-9660

**E-mail:**

Rebecca.Schupp@dhcs.ca.gov

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

**Last Name:**

Arnold

**First Name:**

Majel

**Title:**

Chief, HIV Care Branch / Office of AIDS

<b>Agency:</b>	California Department of Public Health		
<b>Address:</b>	MS 7700		
<b>Address 2:</b>	P.O. Box 997426		
<b>City:</b>	Sacramento		
<b>State:</b>	California		
<b>Zip:</b>	95899-7426		
<b>Phone:</b>	(916) 449-5819	<b>Ext:</b>	<input type="text"/> <input type="checkbox"/> TTY
<b>Fax:</b>	(916) 449-5959		
<b>E-mail:</b>	Majel.Arnold@cdph.ca.gov		

## 8. Authorizing Signature

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

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

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

	1501 Capitol Avenue, Ste. 6000	
<b>Address 2:</b>	PO Box 997413 MS 0000	
<b>City:</b>	Sacramento	
<b>State:</b>	California	
<b>Zip:</b>	95899-7413	
<b>Phone:</b>	(916) 440-7400	Ext: <input type="text"/> <input type="checkbox"/> TTY
<b>Fax:</b>	(916) 440-7404	
<b>E-mail:</b>	Jennifer.Kent@dhcs.ca.gov	
<b>Attachments</b>		

**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

N/A

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

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

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

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

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

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the*

*state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

California assures that the settings transition plan included with this renewal will be subject to any provisions or requirements included in California's approved Statewide Transition Plan. California will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Statewide Transition Plan regarding the HIV/AIDS Waiver:

The purpose of this waiver is to allow persons of all ages with mid- to late-stage HIV/AIDS to remain in their homes through a continuum of care designed to stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to institutional care in hospitals or nursing facilities. Services include, but are not limited to, enhanced care management, homemaker and attendant care services, nutritional counseling and supplements, psychotherapy, and non-emergency medical transportation.

HIV/AIDS provider types include the following:

- Building Contractor or Handyman
- Clinical Psychologist
- Specialized Medical Supplies
- Non-Emergency Transport
- Foster Parent
- Home Health Agency
- Home Health Aide
- Homemaker
- Licensed Clinical Social Worker
- Licensed Vocational Nurse
- Local Pharmacy or Vendor
- Marriage and Family Therapist
- Master's Degree Nurse, Psychiatric or Mental Health Clinical Nurse Specialist, or Psychiatric and Mental Health Nurse Practitioner
- Private Nonprofit or Proprietary Agency
- Registered Dietitian
- Registered Nurse
- Social Work Case Manager
- Waiver Agency with Exemption Approved by CDPH/Office of AIDS

The compliance determination process includes all of the following:

For settings presumed not to be HCB settings, pursuant to CMS regulations, evidence will be provided to CMS for application of the heightened scrutiny process. Such settings will be identified through the review of state laws and regulations, provider and beneficiary self-surveys, existing monitoring and oversight processes and stakeholder input throughout the transition process.

- For all other settings, a sample of on-site assessments will be conducted. The sample results will be used to inform the stakeholder process as changes are made to the system to ensure monitoring and ongoing compliance through standard processes, such as licensing and/or certification. The sample results will also be used to guide the process of bringing HCB settings into compliance.
- The State departments have developed an agency-wide core On-Site Assessment Tool, for use in the on-site assessments of HCB settings. The core assessment tool includes questions that relate to each new federal requirement that will be used to determine if the HCB setting meets or does not meet the required federal rule. The State departments have also developed an agency-wide core Provider Self-Survey Tool, which will be forwarded to all HCB settings for completion. The results of these provider self-surveys will be reviewed by the appropriate State department/entity administering the program, and may trigger on-site assessments when indicators of non-compliance are identified.
- In addition to the core On-Site Assessment Tools and Provider Self-Survey Tools, the State departments, in collaboration with advocacy organizations, are developing core Beneficiary Self-Survey Tools, which will be distributed by the appropriate State department/entity administering the program to Participants throughout the State.
- The written results of each on-site assessment will be forwarded back to the HCB setting with specific information regarding improvements that will be required in order for the setting to come into compliance with the federal requirements and a timeline for completion. Follow up of the compliance issues will be the responsibility of the administering State

department/entity.

- The outcome of the on-site assessments will be reported by each requirement and each HCB site where an on-site assessment was conducted. Remedial actions will be developed to include timelines, milestones and a description of the monitoring process to ensure timelines and milestones are met.

All State-level and individual-setting level remedial actions will be completed no later than March 17, 2019.

The State will ensure that HCB settings remain in compliance with the new requirements by utilizing current ongoing licensing and/or certification processes for both residential and non-residential settings, as well as weaving compliance reviews into current monitoring and oversight processes.

Stakeholder input:

The State conducted two public comment periods and did not receive comments from HIV/AIDS Stakeholders regarding the Transition Plan.

Systemic assessment:

Provider Setting Type – Foster Family Home

HCBS Setting Requirement # Requirement Met, Partially Met, Conflicting, Silent Remedial Strategy Timeline for Completion

1 Met

T22 Section 89372 None Not Applicable

2 Met

T22 Section 89372

Silent:

Option for private unit

Documentation of identified setting options not selected by consumer The State updated setting requirements to comport with the HCBS setting rule. September 30, 2016

3 Met

T22 Section 89372 None Not Applicable

4 Met

T22 Section 89372 None Not Applicable

5 Silent

Choice in services and supports and who provides them The State updated setting requirements to comport with the HCBS setting rule. September 30, 2016

6 Met

1915(c) – Appendix C-2: Facility Specifications None Not Applicable

7 Met

T22 Section 89372

Silent:

Privacy in living unit

Lockable doors

Choice of roommates

Furnish sleeping units The State updated setting requirements to comport with the HCBS setting rule. September 30, 2016

8 Met

22 CCR Section 89376 None Not Applicable

9 Met

22 CCR Section 89372 None Not Applicable

10 Met

22 CCR Section 80087, 80088 None Not Applicable

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

N/A

## Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

**California Department of Public Health**

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

## Appendix A: Waiver Administration and Operation

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**2. Oversight of Performance.**

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DHCS serves as the SSMA in exercising administrative authority over the AIDS Waiver and serves as the primary liaison with CMS. Through an Interagency Agreement (IA) with DHCS, the California Department

of Public Health, Office of AIDS (CDPH/OA) administers the programmatic component of the AIDS Waiver, under DHCS monitoring, oversight, and administrative discretion, and according to federal and state statutes and regulations. DHCS/ LTCD and CDPH/OA maintain a formal system to monitor quality control, provider standards, plans of care, and services provided to participants to ensure the health and welfare needs of individuals served under the AIDS Waiver are continuously met and protected.

Functions delegated to CDPH/OA include:

- Providing waiver services to Medi-Cal members with HIV/AIDS who would otherwise be institutionalized;
- Assuring beneficiary enrollment does not exceed the statewide enrollment capacity as identified in the waiver;
- Ensuring that Medi-Cal members who receive AIDS Waiver services meet the nursing facility level of care;
- Maintain separate contracts with each AIDS Waiver Agency;
- Provide training and technical assistance to AIDS Waiver Agencies and identify deficient areas of program administration;
- Serve as the central point of contact for AIDS Waiver Agencies;
- Develop and promulgate all policies, procedures, and related memoranda regarding the AIDS Waiver;
- Maintain adequate safeguards and standards as set forth in the AIDS Waiver for providers that perform services under the AIDS Waiver;
- Perform AIDS Waiver Agency program compliance reviews in accordance with the AIDS Waiver including monitoring and oversight of level of care, participant centered service plans, providers, fiscal administration, administrative authority, and participant health and welfare; and,
- Perform financial monitoring and oversight of AIDS Waiver Agencies including AIDS Waiver Agencies' fiscal policies and procedures, and appropriateness of expenditures.

LTCD administrative oversight activities include:

- Serving as liaison with CMS;
- Providing technical assistance and policy consultation to CDPH/OA (e.g., Medi-Cal program data, changes to the Medi-Cal program, cost neutrality);
- Resolving policy and system issues in accordance with CMS requirements, state laws, and regulations;
- Preparing expenditure reports for the federal CMS;
- Reviewing other required deliverables for submission to CMS (e.g., quarterly and annual reports);
- Meeting , in collaboration with CDPH/OA, with stakeholders, advocacy groups, private insurers, local governments, and other state agencies to address emerging issues;
- Providing oversight for the AIDS Waiver amendments and renewals;
- Providing updates to CDPH/OA regarding staffing changes and assigned duties; and
- Oversees AIDS Waiver Agency payments via the State Fiscal Intermediary, and provides payment data to CDPH/OA on an as-needed basis.

LTCD shall conduct sufficient collaborative site visits per calendar year to review:

- Eligibility;
- Necessity of services;
- Appropriateness of services;
- Appropriate problem follow-up;
- Level of care determinations;
- Timelines and appropriateness of assessments and reassessments; and
- Timelines of Notices of Action.

LTCD shall also review Program Compliance Review Reports, and Corrective Action Plans (CAP).

## Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

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

## Appendix A: Waiver Administration and Operation

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

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

County Public Health Departments perform waiver operational and administrative activities/functions through a contractual agreement with CDPH/OA.

These entities must meet CDPH/OA performance standards and requirements, including the demonstrated organizational, administrative and financial capabilities to carry out the contractual responsibilities of a waiver.

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

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

Home health agencies, outpatient departments of hospitals licensed and certified by the State, and community-based organizations perform operational and administrative activities/functions through a contractual agreement with CDPH/OA.

These entities must meet CDPH/OA performance standards and requirements, including the demonstrated organizational, administrative and financial capabilities to carry out the contractual responsibilities of a waiver.

## Appendix A: Waiver Administration and Operation

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

California Department of Public Health, Office of AIDS, HIV Care Branch, Medi-Cal Waiver Program Section.

## Appendix A: Waiver Administration and Operation

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**6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative

functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

CDPH/OA maintains a formal system to monitor quality control, provider standards, participant centered care service plans, and services provided to participants to ensure the health and welfare needs of individuals served under the AIDS Waiver are continuously met and safeguarded. These monitoring activities include conducting onsite program compliance reviews (PCR), and review and evaluation of: prior PCR summaries, provider quality improvement/quality management (QI/QM), progress reports, paid claims data, and collection of federally required fiscal audits. CDPH/OA reports monitoring activities results to LTCD.

#### PCR:

A CDPH/OA PCR team consisting of a Nurse Consultant, Social Work Consultant, and program staff conducts a comprehensive PCR of each AIDS Waiver agency at least once every 24 months. A pre-determined portion of PCRs (frequency is determined annually by LTCD) are conducted in collaboration with a LTCD Nurse Evaluator II. The PCR consists of a contract monitoring component and participant chart review component.

The contract monitoring component reviews and evaluates:

- Subcontracts and subcontractors requirements;
- Caseload requirements;
- Provider licensure and qualification requirements;
- Written policies and procedures; and
- Fiscal requirements.

The participant chart review component reviews and evaluates:

- Waiver eligibility including appropriate level of care assessments;
- Consent forms;
- Necessity and appropriateness of services;
- Timeliness and appropriateness of assessments, reassessments, participant centered service plans;
- Appropriate notice of action when applicable;
- Appropriate follow-up on participant grievances; and
- Appropriateness of payment for services delivered.

#### Provider QI/QM Review:

CDPH/OA requires AIDS Waiver Agencies to implement a QI/QM program using CDPH/OA established guidelines to continually evaluate and improve the quality of services provided. AIDS Waiver Agencies submit an annual QI/QM plan and a summary of QI/QM monitoring results to CDPH/OA semi-annually. AIDS Waiver Agencies survey participants for satisfaction as part of their QI/QM activities and are required to submit summaries of the survey results to CDPH/OA for review. If CDPH/OA discovers problems or issues, CDPH/OA shall provide technical assistance to the AIDS Waiver Agency. AIDS Waiver Agencies shall include any issue or problem discovered by CDPH/OA for review on the subsequent QI/QM monitoring plan(s). CDPH/OA reviews these problems and/or issues during subsequent PCR, or as warranted.

#### Progress Reports Review:

AIDS Waiver Agencies are required to submit progress reports bi-annually to CDPH/OA. The progress report provides monitoring information including: number of participants served by county, subcontractors, and types of contracted services, key staff and service providers' information (including licensure and/or certifications, and training), trends and barriers, participant grievances/requests for State Fair Hearings, risk assessment and mitigation, and technical assistance needs.

CDPH/OA staff reviews and evaluates the progress reports and follows up with AIDS Waiver Agencies to provide technical assistance and guidance as needed.

#### Fiscal Audits Review:

Annually, AIDS Waiver Agencies are required to submit copies of fiscal audits to the State within timeframes set forth in the United States Office of Management Budgets Circular A-133 or in the California Health and Safety Code §§38040 – 38041. CDPH/OA follows up on untimely audits. Per an Interagency Agreement, DHCS Audits & Investigations periodically conducts audits on CDPH/OA contracts with AIDS Waiver Agencies, and will request fiscal audit documentation as part of the overall audit. If there are findings of non-compliance with AIDS Waiver requirements, the AIDS Waiver Agency is given written notice of what corrective action is necessary and the timeline for completing the corrective action. Review of the AIDS Waiver Agency's corrective action efforts are

followed up on at subsequent program compliance reviews until compliance is reached.

CDPH/OA:

CDPH/OA is responsible for administering and monitoring the programmatic components of the AIDS Waiver. CDPH/OA reports result from monitoring activities to LTCD.

CDPH/OA operational and administrative oversight responsibilities include:

- Chief, Medi-Cal Waiver Program Section - Oversight of all AIDS Waiver program activities;
- Nurse Consultant – Serves as the Quality Improvement/Quality Management Coordinator;
- Nurse Consultant and Social Work Consultant - Serve as clinical contacts for AIDS Waiver Agencies and are responsible for clinical oversight.

Nurse Consultant, Social Work Consultant and program staff:

- Conduct and follow-up on PCRs to assure compliance with program requirements and the provision of quality care for AIDS Waiver participants;
- Provide consultation and technical assistance to AIDS Waiver Agencies regarding state and federal requirements, contract provisions, program policies and procedures, etc.;
- Provide orientation and training to AIDS Waiver Agency personnel as needed;
- Assist in AIDS Waiver policy development, revision, and implementation;
- Coordinate and provide guidance to AIDS Waiver Agencies related to State Fair Hearings;
- Perform functions related to continued Federal authorization of AIDS Waiver including renewals, amendments, eligibility criteria, services, standards, financial reporting, and cost neutrality;
- Develop policy manual and systems;
- Enroll/disenroll providers and participants;
- Maintain a State Fair Hearing log and policy and procedure guide;
- Periodically review and analyze enrollment and demographic reports, and perform follow-up as needed.

## Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

#### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

#### Performance Measure:

**#/% of required quarterly oversight meetings conducted between OA and Medicaid agency (LTCB) (waiver enrollment, PCSP, QI, trends and significant deficiencies)**

**Numerator - Number of oversight meetings conducted / Denominator - Total number of planned oversight meetings**

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

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

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of Medicaid agency review (LTCD) of Summary of Findings Reports generated by OA**  
**Numerator - Number of Summary of Findings Reports reviewed by Medicaid agency/**  
**Denominator - Total number of Summary of Findings Reports generated by OA**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**CDPH/OA provides copies of all Summary of Findings reports to the State Medicaid agency**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

#/% of policies/procedures issued by the OA that have been reviewed and approved by the Medicaid agency prior to implementation  
**Numerator - Number of policies /procedures reviewed and approved by the Medicaid agency/ Denominator - Total number of policies/procedures issued by OA**

**Data Source (Select one):**

**Presentation of policies or procedures**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="text"/>	<input type="text"/>	<input type="text"/>

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of Waiver agencies that submit a timely annual QI/QM plan Numerator - Number of timely annual QI/QM plan submitted/ Denominator - Total number of Waiver agencies**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Annual Progress Reports**

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

**Data Aggregation and Analysis:**

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

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
CDPH/OA works collaboratively with the AIDS Waiver Agency’s Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the AIDS Waiver Agency during the exit conference, and a formal written Summary of Findings is provided to the AIDS Waiver Agency following the review. The AIDS Waiver Agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the AIDS Waiver Agency appropriately addresses the findings.
- ii. **Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	HIV/AIDS	0		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Individuals in a target group must:

- Have a written diagnosis of HIV disease or AIDS from his/her primary care provider. For pediatric participants under 13 years of age, the written diagnosis is documented on the Centers for Disease Control and Prevention (CDC) Classification System for HIV in Children Under 13 Years of Age form. For individuals 13 years of age and over, the written diagnosis is documented on the AIDS Waiver Certification of Eligibility form;
- Not be simultaneously enrolled in the Medi-Cal Hospice Program (may be simultaneously enrolled in Medicare Hospice);
- Not be simultaneously enrolled in another Medi-Cal Home and Community-Based Services Waiver;
- Not be simultaneously receiving State Plan case management services or Targeted Case Management to supplement AIDS Waiver;
- Be certified to meet the Nursing Facility Level of Care (NF LOC) or the Acute Level of Care (A LOC) as described in Title 22, California Code of Regulations, Sections 51120, 51120.5, 51121, 51124, 51215, 51334 and 51335;
- Score at 60 or less on CDPH/OA’s Cognitive Functional Ability (CFA) scale if over 13 years of age.

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

**Appendix B: Participant Access and Eligibility**

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

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

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

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

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

Specify the percentage:

- Other**

*Specify:*

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

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

The State does not refuse home or community-based services to any participant even though the State may reasonably expect the cost of services to exceed the individual cost limit specified by the State. The State provides home or community-based services to any otherwise eligible participant up to the maximum allowable amount as indicated by the State specified individual cost limit. At the time of AIDS Waiver enrollment, participants sign an Informed Consent/Agreement to Participate document through which they are informed of the individual cost limit of \$13,209 per AIDS Waiver year and by which all participants, upon reaching this limit, are disenrolled from the AIDS Waiver. Upon disenrollment, participants receive information about the State Fair Hearing process. Information on other resources within the community is provided to ensure the continued health and welfare of the participant.

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

- The following dollar amount:**

Specify dollar amount:

**The dollar amount (*select one*)**

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

Prior to enrollment, AIDS Waiver case managers conduct a comprehensive assessment of the applicant to determine service needs. Case managers, with participant's input, develop a Participant Centered Service Plan delineating how participant's needs are to be met and the funding source for all services. Of the services identified, only those services which exist in addition to State Plan services, other services, and supports, and which are used as the payer of last resort may be provided to a participant under the AIDS Waiver. Participants receive services under the AIDS Waiver based on need until individual cost cap is reached. When the cost cap is reached, the participant is disenrolled from the AIDS Waiver and informed of his/her right to request a State Fair Hearing. When a participant is disenrolled from the AIDS Waiver, he/she may be enrolled in the CDPH/OA Ryan White Program, or provided services from other available funding sources to ensure the continued health and welfare of the participant. As long as the participant remains eligible for Medi-Cal, the participant will continue to receive all of the Medi-Cal State Plan services he/she was eligible to receive while enrolled in the AIDS Waiver. The scope of services provided by other funding sources may differ from AIDS Waiver services.

Denial of the Waiver due to AIDS Waiver Agencies' inability to serve additional participants: When the instance arises where an AIDS Waiver Agency is unable to serve a potential Waiver participant due to limitations in staffing, it is the AIDS Waiver Agency's responsibility to refer those participants to other resources such as the Ryan White Program, or provide services from other available funding sources to ensure the continued health and welfare of the participant.

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

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

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

- Other safeguard(s)**

*Specify:*

If an AIDS Waiver participant maximizes his/her individual cost limit, as indicated above, he/she is provided a Notice of Action (NOA) 10 days prior to being disenrolled from the AIDS Waiver, and Notice of the Right to File a State Fair Hearing within 90 days of the date of the NOA. The participant is informed of other options and referrals are made to other services in the community to address the health and welfare of the participant. At the beginning of the subsequent calendar year, if the individual is still eligible for the AIDS Waiver, he/she may be reenrolled.

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1551
Year 2	1443
Year 3	1342
Year 4	1248
Year 5	1160

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

## Appendix B: Participant Access and Eligibility

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

*Select one:*

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

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

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

The AIDS Waiver provides for the entrance of all eligible persons up to the capacity of the Waiver as long as there is an AIDS Waiver agency serving an applicant's county of residence, and available slots within the AIDS Waiver Agency.

The State may submit a waiver amendment to CMS to modify the number of participants specified for any year(s) where the capacity is reached. When capacity is reached, entrance to the waiver of otherwise eligible applicants will be deferred until capacity becomes available.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

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

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

**2. Miller Trust State.**

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

- No  
 Yes

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

---

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

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

*Select one:*

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

Specify percentage:

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

*Specify:*

Blind Individuals Who Would Otherwise Be Eligible For The SSI/SSP Program.

---

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

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

*Select one and complete Appendix B-5.*

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

*Check each that applies:*

**A special income level equal to:**

*Select one:*

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

Specify percentage:

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

Specify dollar amount:

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

*Select one:*

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

Specify percentage amount:

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan**

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard**
- The special income level for institutionalized persons

(*select one*):

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

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

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

*Specify:*

- Other**

*Specify:*



---

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

---

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

*Specify:*

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

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

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

- The amount is determined using the following formula:**

*Specify:*



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

---

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

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

- The amount is determined using the following formula:**

*Specify:*

**Other**

*Specify:*

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

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

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

**i. Allowance for the personal needs of the waiver participant**

*(select one):*

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**

- The special income level for institutionalized persons**  
 **A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

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

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

*Specify formula:*

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

- Other**

*Specify:*

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

Select one:

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

*Explanation of difference:*

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

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

Select one:

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

## **Appendix B: Participant Access and Eligibility**

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

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

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


---

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

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**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (6 of 7)**

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

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


---

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

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**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (7 of 7)**

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

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

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

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

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**Appendix B: Participant Access and Eligibility****B-6: Evaluation/Reevaluation of Level of Care**

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

*Specify the entity:*

- Other**  
*Specify:*

Local/Regional Non-State entities herein after referred to as AIDS Waiver Agencies perform evaluations/reevaluations.

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

**Nurse Case Manager:** A Registered Nurse (RN) licensed by the State of California who has two years of experience as an RN, with at least one year in community nursing. It is desirable, but not mandatory, that the RN Case Manager has obtained a Bachelor of Science degree in Nursing (BSN), and has a Public Health Nurse (PHN) certificate.

**Social Work Case Manager:** An individual licensed by the State of California as a Licensed Clinical Social Worker, Marriage and Family Therapist, or Psychologist, or an individual with a Master's Degree in Social Work, Counseling, or Psychology, as approved by CDPH/OA.

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

- Nursing Facility Level of Care, Title 22, California Code of Regulations, Sections 51334 and 51335
- Nursing and psychosocial assessments
- Adults scored at 60 or less on CDPH/OA's Cognitive Functional and Ability (CFA) scale

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

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

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

In conjunction with the Nursing Facility Level of Care and assessments/reassessments, the AIDS Waiver Agency uses the Cognitive Functional Ability (CFA) scale to summarize the participant's condition. The CFA scale was developed to adapt the Karnofsky Performance Scale to be more specific to adults with HIV or AIDS. The CFA scale is based on the findings of the Nursing Assessment and Psychosocial Assessment, and produces a numerical score. Individuals must have a CFA score of 60 or less to be eligible for the AIDS Waiver.

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

Assessments - All applicants are screened for eligibility and receive face-to-face comprehensive assessments by qualified case managers who meet the State's licensing and other program requirements. The level of care evaluation process includes:

- Nursing Assessment on or within 15 days prior to enrollment. This assessment includes a comprehensive medical review and also identifies participant's care needs, evaluates participant's health condition, and risk and history of abuse. It also assists with formulation of the PCSP and with coordination of care;
- Nursing Facility Level of Care (NF LOC) Certification on or within 15 days prior to enrollment per Title 22 of the California Code of Regulations, sections 51134 and 51335;
- Psychosocial Assessment on or within 15 days prior to enrollment. This assessment provides information about participant status in the following areas: social, emotional, behavioral, mental, spiritual, legal, financial, environmental, and risk and history of abuse. It also assists with formulation of the PCSP and with coordination of care;
- Cognitive Functional Ability (CFA) scale scoring of 60 or below on or within 15 days of enrollment; and
- Reassessments – All applicants receive face-to-face comprehensive Nursing and Psychosocial reassessments by qualified case managers at least every 180 days, which include CFA scoring.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months
- Every six months
- Every twelve months
- Other schedule

*Specify the other schedule:*

At least every 180 days, or sooner if the participant's condition changes.

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

*Specify the qualifications:*

**i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Reassessments are performed by qualified case managers every 180 days.

During AIDS Waiver Agency Program Compliance Reviews (PCR), which occurs at least once every 24 months, CDPH/OA and LTCD review participant files to determine if reassessments are complete, accurate, and timely. At the end of the PCR, CDPH/OA staff identifies areas requiring correction, and provide feedback and extensive technical assistance (TA) to AIDS Waiver Agency staff. Within 30 days of completing the PCR, CDPH/OA sends a written Summary of Findings to the AIDS Waiver Agency in which findings and any areas requiring corrective action are identified. When corrective action is needed, the AIDS Waiver Agency must submit a Corrective Action Plan (CAP) to CDPH/OA within 60 days of receipt of CDPH/OA's written report. CDPH/OA staff review and evaluate the CAP and may approve none, some, or all the actions. If actions do not adequately address the finding(s), the AIDS Waiver Agency will be required to submit an updated CAP. CDPH/OA staff work with the AIDS Waiver Agency until all findings are remediated. At the subsequent compliance review, CDPH/OA staff review the areas where findings and corrective action were required. Based on its review, CDPH/OA staff discusses areas of improvement and areas needing improvement with AIDS Waiver Agency staff, and provides TA as necessary.

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

AIDS Waiver Agencies must follow the accepted guidelines for record handling and documentation practices for health care records. Participant service records, including initial assessments and reassessments, must be:

- Kept at each site according to the contract obligation to CDPH/OA;
- Kept in writing or an electronically-retrievable form at each AIDS Waiver Agency and for a minimum period of three years from the date of final payment under the contract;
- Kept in a locked storage area accessible only to AIDS Waiver Agency staff directly responsible for filing, charting, and reviewing, and State and Federal representatives, as required by law; and
- Protected from potential damage.

No documents shall be destroyed or removed from a record once entered. AIDS Waiver Agencies must maintain a plan for record storage and retrieval if the organization were to close. Policies must meet the minimum requirements for record handling and documentation practices for health care records as established for AIDS Waiver Agencies.

## Appendix B: Evaluation/Reevaluation of Level of Care

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### Quality Improvement: Level of Care

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

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

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**#/% of waiver participants who received a LOC evaluation prior to enrollment**  
**Numerator - Number of waiver participant who received a LOC evaluation prior to enrollment / Denominator - Total number of participants enrolled**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of waiver participants who received an initial LOC evaluation that was completed by a qualified provider. Numerator - Number of waiver participants who received an initial LOC evaluation that was completed by a qualified provider/ Denominator - Total number of charts reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size
	<input checked="" type="checkbox"/> Other Specify: Biennially	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/ % of Waiver participants whose documentation supports initial LOC determination. Numerator - Number of waiver participants where documentation supports the initial LOC determination/ Denominator- Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size

	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of Waiver participants who received an Initial Nursing Assessment**  
**Numerator - Number of waiver participants who received an Initial Nursing Assessment/ Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of Waiver participants who received an Initial Psychosocial Assessment**  
**Numerator - Number of waiver participants who received an Initial Psychosocial Assessment/ Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of waiver participants who received an Initial Cognitive and Functional Ability Assessment Numerator - Number of waiver participants who received an Initial Cognitive and Functional Ability Assessment/ Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of waiver participants who received a Certification of Eligibility Numerator - Number of waiver participants who received a Certification of Eligibility / Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size
	<input checked="" type="checkbox"/> Other Specify: Biennially	

**Data Aggregation and Analysis:**

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

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
CDPH/OA works collaboratively with the AIDS Waiver Agency’s Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the AIDS Waiver Agency during the exit conference, and a formal written Summary of Findings is provided to the AIDS Waiver Agency following the review. The AIDS Waiver Agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the AIDS Waiver Agency appropriately addresses the findings.
- ii. **Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

**c. Timelines**

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

- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

When an individual is determined eligible for the AIDS Waiver, the AIDS Waiver case managers describe waiver services, limitations, requirements, and any feasible alternative programs. The individual is then given the choice between the AIDS Waiver and other care/institutionalization. The Informed Consent/Agreement to Participate, Participant's Rights in Case Management, Grievance Policy, and AIDS Waiver Notice of Action: Your Right to a State Fair Hearing forms are reviewed with the participant and/or legal representative and questions are answered. If AIDS Waiver services are chosen, the individual signs the Informed Consent/Agreement to Participate form, initialing and dating acknowledgment and receipt of participant's rights and responsibilities, grievance procedures, and Notice of Action information.

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

All initial enrollment forms are maintained for a minimum of three years from the date of final payment under the contract and kept in the participant's service record/chart stored at each AIDS Waiver Agency.

## Appendix B: Participant Access and Eligibility

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

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

AIDS Waiver Agencies make every effort to assure access to oral and written assistance to Limited English Proficient (LEP) persons. CDPH/OA requires AIDS Waiver Agencies to:

- Conduct community outreach to reach populations and/or groups in the community who are institutionalized or disproportionately affected by HIV/AIDS, and provide meaningful access to services for all persons, including those with LEP;
- Make every effort to assure meaningful access to bilingual service providers and interpreter services for participants whose ability to speak and/or understand English is limited; and
- AIDS Waiver required participant forms are available in English and Spanish, i.e., Informed Consent/Agreement to Participate, Authorization to Exchange Confidential Information, Participant Rights in Case Management, and Notice of Action: Request for a State Fair Hearing. Currently, CDPH/OA is unaware of current need for participant forms in other languages but, if a need arises, CDPH/OA will have the forms translated.

## Appendix C: Participant Services

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

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Enhanced Case Management		
Statutory Service	Homemaker		
Other Service	Attendant Care		
Other Service	Home-Delivered Meals / Nutritional Supplements		
Other Service	Medi-Cal Supplements for Infants and Children in Foster Care		
Other Service	Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies		
Other Service	Non-Emergency Medical Transportation		

Service Type	Service		
Other Service	Nutritional Counseling		
Other Service	Psychotherapy		
Other Service	Skilled Nursing, Licensed Vocational Nurse		
Other Service	Skilled Nursing, Registered Nurse		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service 

**Service:**

Case Management 

**Alternate Service Title (if any):**

Enhanced Case Management

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Enhanced Case Management:

Enhanced Case Management consists of identifying service needs, locating, coordinating and supervising services rendered to persons with a diagnosis of HIV /AIDS, in accordance with identified needs as set forth in a written participant centered service plan and in consideration of the participant's health and welfare. Enhanced Case Management ensures access to services, regardless of funding source. This service is primarily for the benefit of the AIDS Waiver participant.

Enhanced Case Management includes an initial face-to-face comprehensive nursing and psychosocial assessment, monthly face-to-face contact by a case manager, and ongoing comprehensive reassessments every 180 days that provide information about each participant's service needs and the development, implementation,

and periodic evaluation of the written participant centered service plan.

Enhanced Case Management is a collaborative and interdisciplinary approach, performed by a team consisting of case managers, foster child care worker (if applicable), Primary Care Provider, parent or guardian of a child with HIV/AIDS and participant or legal representative.

Enhanced Case Management services under the AIDS Waiver differ from the scope and nature of case management services under the State Plan. Under the AIDS Waiver, services are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the participant. Under the State Plan, services are concentrated on referring and coordinating services. Under the AIDS Waiver, reassessments are conducted every 180 days with monthly face-to-face participant contact to ensure participant's health and welfare the necessity and quality of direct care services. Under the State Plan, reevaluations are conducted every six months to evaluate the beneficiary's progress toward achieving the objectives in the service plan.

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

AIDS Waiver Agencies' case management services are reimbursed a monthly flat fee per participant for enrolled participants.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Social Work Case Manager
Agency	Registered Nurse (RN) Case Manager

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Enhanced Case Management**

**Provider Category:**

Agency ▼

**Provider Type:**

Social Work Case Manager

**Provider Qualifications**

**License** (*specify*):

Licensed Clinical Social Worker:

CCR, Title 16, Division 18 and Business and Professions Code (BPC) Division 2, Chapter 14, Articles 1-4, Sections 4990-4998.7

OR

Marriage and Family Therapist:

CCR Title 16, Division 18 and BPC Chapter 13, Article 1-7, Sections 4980-4989

OR

Psychologist:

CCR, Title 16, Division 13.1 and BPC, Chapter 6.6, Section 2903

**Certificate** (*specify*):

N/A

**Other Standard** (*specify*):

An individual licensed by the State of California as a Licensed Clinical Social Worker, Marriage and Family Therapist, or Psychologist, or an individual with a Master's Degree in Social Work, Counseling, or Psychology, as approved by CDPH/OA.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Licensed Clinical Social Worker:

Department of Consumer Affairs, Board of Behavioral Sciences  
Project Director or Personnel Office at the AIDS Waiver Agency

Marriage and Family Therapist

Department of Consumer Affairs, Board of Behavioral Sciences  
Project Director or Personnel Office at the AIDS Waiver Agency

Psychologist

Department of Consumer Affairs, Board of Psychology  
Project Director or Personnel Office at the AIDS Waiver Agency

Master of Social Work, Counseling, or Psychology approved by CDPH/OA  
Project Director or Personnel Office at the AIDS Waiver Agency.

**Frequency of Verification:**

Licensed Clinical Social Worker:

Every two years

Prior to/at time of employment

Marriage and Family Therapist

Every two years

Prior to/at time of employment

Psychologist

Every two years

Prior to/at time of employment

Master of Social Work, Counseling, or Psychology approved by CDPH/OA  
Prior to/at time of employment with proof of Master's degree.

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**

**Service Name: Enhanced Case Management**

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**Provider Category:**

Agency  

**Provider Type:**

Registered Nurse (RN) Case Manager

**Provider Qualifications**

**License (specify):**

California Code of Regulations (CCR), Title 16, Section 1409, Nursing Practice Act, Division 2, Chapter 6, Article 1, Section 2732

**Certificate (specify):**

N/A

**Other Standard (specify):**

Two years of experience as an RN, with at least one year in community nursing. It is desirable that the RN obtain a Bachelor of Science degree in Nursing and a Public Health Nurse certificate.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Consumer Affairs, Board of Registered Nursing

Project Director or Personnel Office at the AIDS Waiver Agency

**Frequency of Verification:**

Every two years

Prior to/at time of employment

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service ▼

**Service:**

Homemaker ▼

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Homemaker services consist of general household activities performed when an individual who is regularly responsible for these activities is temporarily absent or unable to manage the home, or care for him/herself or others in the home. These services allow individuals to continue to live independently.

Services rendered are in addition to, not in place of, services authorized under the Medi-Cal State Plan, the In-Home Supportive Services (IHSS) 1915(j) option, and the Personal Care Services Program. The HIV/AIDS level of need is greater than others under the State Plan.

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

Homemaker services are provided to participants whose needs exceed the maximum amount available under the State Plan. The need, quantity, frequency, and duration for services will be determined by the qualified case manager as part of his/her regular assessments and reassessments.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Private Nonprofit or Proprietary Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Homemaker**

**Provider Category:**

Agency ▼

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** (*specify*):

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725

**Certificate** (*specify*):

N/A

**Other Standard** (*specify*):

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Must provide basic training on HIV/AIDS, infection control, and confidentiality.

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CDPH Licensing and Certification and the AIDS Waiver Agency Project Director.

**Frequency of Verification:**

Prior to/at time of contract and every 12 months thereafter.

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**  
**Service Name: Homemaker**

---

**Provider Category:**

**Provider Type:**

Private Nonprofit or Proprietary Agency

**Provider Qualifications****License (specify):**

Local California business license.

**Certificate (specify):**

N/A

**Other Standard (specify):**

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Must provide basic training on HIV/AIDS, infection control, and confidentiality.

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

The AIDS Waiver Agency Project Director and CDPH/OA as appropriate.

**Frequency of Verification:**

Prior to/at time of contract and every 12 months thereafter.

## Appendix C: Participant Services

---

### C-1/C-3: Service Specification

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

**Service Type:**


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

**Service Title:**

Attendant Care

**HCBS Taxonomy:****Category 1:**

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

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

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


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

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

**Service Definition (Scope):**

Attendant care services provide a higher level of care for persons with HIV/AIDS who have needs that change on a routine basis and are different in nature from State Plan services. They must be provided by a Certified Home Health Aide (CHHA), Certified Nursing Assistant (CNA), or a person with CDPH Licensing and Certification Division's written approval of training equivalent to a CNA. Allowable attendant care services differ based on a provider's qualifications.

**CHHA:**

Through a licensed home health agency or hospice program, and under the instruction and supervision of a registered nurse, CHHAs provide basic nursing services, food preparation, and household services for individuals receiving Primary Care Provider-prescribed care. A CHHA may not provide any services that require a professional nursing or medical license. The CHHA communicates with the individual, observes responses to treatment and/or environment, and reports responses to a licensed nurse or therapist; provides and records personal care and comfort measures; and performs the following procedures:

- Prepares meals and assists individuals with eating;
- Assists with use of bedpan, urinal, and commode;
- Takes vital signs: temperature, pulse, respirations, and blood pressure;
- Measures height and weight; and
- Performs other activities taught by a health professional for a specific participant, (i.e. changing colostomy bags or non-sterile dressings).

**CNA:**

Under the supervision of a licensed nurse (registered or vocational), the CNA provides basic nursing services to ensure the safety, comfort, personal hygiene, and protection of individuals. CNAs may not perform any nursing services that require a professional nursing license. The CNA communicates with the individual, observes responses to treatment and/or environment, and reports responses to a licensed nurse; provides personal care and comfort measures; and performs the following procedures:

- Feeds individuals;
- Takes vital signs: temperature, pulse, respirations, and blood pressure;
- Measures height and weight;
- Assists with use of bedpan, urinal, and commode; and
- Assists with bowel and bladder retraining.

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

Attendant Care services are provided to participants whose needs exceed the maximum amount available under the State Plan. The need, quantity, frequency, and duration for services will be determined by the qualified case manager as part of his/her regular assessments and reassessments.

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

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

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

- Legally Responsible Person**

- Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Private Nonprofit or Proprietary Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Attendant Care**

**Provider Category:**

Agency ▼

**Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725

**Certificate (specify):**

N/A

**Other Standard (specify):**

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Must provide basic training on HIV/AIDS, infection control, and confidentiality.

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CDPH Licensing and Certification and the AIDS Waiver Agency Project Director.

**Frequency of Verification:**

Prior to/at time of contract and every 12 months thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Attendant Care**

**Provider Category:**

Agency ▼

**Provider Type:**

Private Nonprofit or Proprietary Agency

**Provider Qualifications****License (specify):**

Local California business license.

**Certificate (specify):**

N/A

**Other Standard (specify):**

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Must provide basic training on HIV/AIDS, infection control, and confidentiality.

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The AIDS Waiver Agency Project Director and CDPH/OA as appropriate.

**Frequency of Verification:**

Prior to/at time of contract and every 12 months thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service 

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

**Service Title:**

Home-Delivered Meals / Nutritional Supplements

**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**

**Category 2:**



**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Home-Delivered Meals:

Home-delivered meals are provided to meet the nutritional needs of homebound participants who are unable to prepare their own meals and do not have a caretaker at home to prepare meals for them. Home-delivered meals may be provided daily but may not meet all nutritional needs of the participant (three meals a day). The number and frequency of meals to be delivered daily

depends on the requirements of each participant's service plan. An individual may provide home-delivered meals when a "meals-on-wheels" vendor is not available. In these cases, the following documentation must be included in the participant's progress notes:

- There is no "meals-on-wheels" or similar vendor available;
- The amount being reimbursed for food and preparation cost is based on "usual and customary fees" charged by "meals-on-wheels" vendors; and
- The written agreement that outlines the details between the AIDS Waiver Agency and the individual providing the service.

#### Nutritional Supplements:

Nutritional supplements provide AIDS Waiver case managers with additional choices for augmenting a participant's normal resources for purchasing and preparing an adequate nutritional diet that meets the participant's needs. Nutritional supplements are based on the participant's medical condition and not solely on financial need. Documentation must be maintained in the participant's chart indicating the medical condition and need for nutritional supplements. Nutritional supplements may be considered for participants with any of the following conditions:

- Medications and the disease process producing symptoms such as pain, nausea, loss of appetite, bloating or gas, vomiting and diarrhea that become barriers to the participant trying to maintain a nutritional status;
- Weight loss and muscle wasting;
- Disease management that requires special diet; and
- Infections affecting the gastrointestinal system that prevent adequate absorption of food and make nutritional supplements necessary.

Identification of the need for nutritional supplements will depend on service plan requirements. Nutritional supplements are another method used to prevent institutionalization or re-institutionalization of participants. Nutritional supplements include prepackaged nutritionally fortified drinks (liquid or powder), health food bars, herbal therapy, vitamins and other food items that will contribute to the nutritional or caloric intake of the participant. They are, however, not intended to meet all nutritional needs of the participant or provide a full nutritional regimen (three meals a day).

Donated food and food/nutritional supplements purchased with food vouchers may be obtained separately, combined and/or distributed together (for example, items available through food banks or in food bags) and are permissible as nutritional supplements (subject to State policy and procedures). Bottled water is not considered to be a nutritional supplement and cannot be billed to the waiver program. AIDS Waiver shall not be billed for participants receiving donated food or food fully paid for by another funding source.

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

Home-Delivered Meals combined with Nutritional Supplements will not exceed \$150 per participant per month.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

#### **Provider Specifications:**

Provider Category	Provider Type Title
Individual	Local pharmacy or vendor
Agency	Private Nonprofit or Proprietary Agency or Business

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Home-Delivered Meals / Nutritional Supplements**

---

**Provider Category:**

Individual ▾

**Provider Type:**

Local pharmacy or vendor

**Provider Qualifications**

**License (specify):**

Local business license, and any others as required by local governments.

**Certificate (specify):**

N/A

**Other Standard (specify):**

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AIDS Waiver Project Director and CDPH/OA as appropriate.

**Frequency of Verification:**

Prior to/at time of contract and every 12 months thereafter.

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service**

**Service Name: Home-Delivered Meals / Nutritional Supplements**

---

**Provider Category:**

Agency ▾

**Provider Type:**

Private Nonprofit or Proprietary Agency or Business

**Provider Qualifications**

**License (specify):**

Local business license, and any others as required by local governments.

**Certificate (specify):**

N/A

**Other Standard (specify):**

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AIDS Waiver Project Director and CDPH/OA as appropriate.

**Frequency of Verification:**

Prior to/at time of contract and every 12 months thereafter.

## Appendix C: Participant Services

---

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service 

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

**Service Title:**

Medi-Cal Supplements for Infants and Children in Foster Care

**HCBS Taxonomy:****Category 1:**



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



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



**Sub-Category 3:****Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

The Medi-Cal supplements for infants and children in foster care service is intended to facilitate placement efforts and compensate foster parents for increased costs and services when foster care funds, including the Specialized Care Rates program and the Substance Abuse/HIV Infant Program, or other services and supports, are unavailable or insufficient for eligible participants under 18 years of age.

The need for this supplement must be documented in the client's progress notes. The foster home must be approved and licensed according to State law and regulation. The qualified case manager is responsible for obtaining documentation which substantiates licensure. The cost of room and board is not included in this supplement.

AIDS Waiver Agencies must access all other resources, including county funds (for example, foster family home basic rates and specialized care rate incentives and assistance programs), prior to billing the AIDS Waiver for these services. The AIDS Waiver is the payer of last resort after all other sources of funding, including federal, State, local and private entities.

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

This service has a monthly cap of \$338 per participant.

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Foster Parent

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medi-Cal Supplements for Infants and Children in Foster Care

Provider Category:

Individual ▾

Provider Type:

Foster Parent

Provider Qualifications

License (specify):

CCR, Title 22, Division 6, Chapter 9.5

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social Services and individual Counties

Frequency of Verification:

At application, annual training, and/or complaint investigation

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

Service Type:

Other Service ▾

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

Service Title:

Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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

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

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


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

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

**Service Definition (Scope):****Minor Physical Adaptations to the Home**

Minor physical adaptations to the home consist of physical adaptations to the home that are required by the PCSP and are necessary to ensure the health, welfare and safety of the individual, or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are essential for the health and welfare of the participant. Adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant are excluded. Adaptations that add to the total square footage of the home are excluded, except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

If the provision of a service requires obtaining a local building permit(s), the service provider must be licensed. For jobs smaller in scope, AIDS Waiver Agency staff checks references to ensure the legitimacy of the service provider, and documents this information and the type of services provided in the PCSP.

If a AIDS Waiver participant does not own the home where he/she resides, written permission must be obtained from the landlord and noted in the PCSP before making adaptations.

**Specialized Medical Equipment and Supplies**

The specialized medical equipment and supplies service provides devices, controls, or appliances, as specified in the PCSP, which enable individuals to increase their ability to perform daily living activities, or to perceive, control, or communicate with the environment in which they live.

This service also includes the provision of items that are necessary for life support, including all ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment. Items that are not of direct medical or remedial benefit to the individual shall be excluded. All items shall meet applicable standards of manufacture, design and installation.

This service is necessary to provide an alternative to institutionalization and must be immediately needed for the AIDS Waiver participant's care and safety. Purchase authorization shall be granted only when the AIDS Waiver Agency has indicated and documented that good faith efforts to provide specialized medical equipment and supplies through the State Plan have been denied. The AIDS Waiver Agency must also document and justify need for the item(s) in the PCSP.

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

Minor physical adaptations to the home combined with specialized medical equipment and supplies, is not to exceed \$1,000 per participant per calendar year.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Nonprofit or Proprietary Agency or Business

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies**Provider Category:**

Agency ▾

**Provider Type:**

Private Nonprofit or Proprietary Agency or Business

**Provider Qualifications****License** (specify):

Local business license, and any others as required by local governments. If the service requires local building permits, then the service provider must be licensed.

**Certificate** (specify):

N/A

**Other Standard** (specify):
**Verification of Provider Qualifications****Entity Responsible for Verification:**

Project Director at the AIDS Waiver Agency

**Frequency of Verification:**

Prior to/at time of employment.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service ▾

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

**Service Title:**

Non-Emergency Medical Transportation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Non-emergency medical transportation consists of those services which enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies are utilized. Includes non-emergency medical transportation to health and social service providers (e.g., infusion therapy, counseling, support groups, methadone treatment, etc.) stipulated in the client's service plan when the participant does not have the means for transportation or their mobility is limited. Privately owned vehicles may be used when the qualified case manager determines the participant is capable of travel by private vehicle and when a commercial vehicle is not available or is more expensive. Use of taxi/shuttle vouchers and reimbursement of gas and automobile usage (at current State rates) is also permissible.

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

This service is subject to a \$40 monthly cap per participant.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Nonprofit or Proprietary Agency or Business

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Non-Emergency Medical Transportation**

**Provider Category:**

Agency ▼

**Provider Type:**

Private Nonprofit or Proprietary Agency or Business

**Provider Qualifications**

**License (specify):**

Local business license, and any others as required by local governments.

**Certificate (specify):**

**Other Standard (specify):**

CDPH/OA may provide an exemption to a Waiver agency if an individual cannot be contracted for this service and the Waiver agency has a qualified individual who can provide the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Project Director at the AIDS Waiver Agency.

**Frequency of Verification:**

Prior to/at time of employment.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Nutritional Counseling

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



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


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

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

**Service Definition (Scope):**

This service provides participants and their caregivers with guidance on the promotion of eating habits and food choices that maximize nutritional opportunities for the participant who is faced with disease symptoms such as nausea or diarrhea, and prevent potential drug/food interactions. Food choices can be planned to meet ethnic and personal choices and financial constraints. This service will be provided by a Registered Dietitian who has indicated by agreement with the AIDS Waiver Agency to provide nutritional counseling services on a consultant basis.

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

Services will be paid for based on an hourly rate and the frequency and need for services will be determined by the qualified RN case manager.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Nonprofit or Proprietary Agency or Business
Individual	Registered Dietitian

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Other Service**

**Service Name: Nutritional Counseling**

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**Provider Category:**

Agency

**Provider Type:**

Private Nonprofit or Proprietary Agency or Business

**Provider Qualifications****License (specify):**

Local business license, and any others as required by local governments.

**Certificate (specify):**

N/A

**Other Standard (specify):**

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Project Director at the Waiver agency and CDPH/OA as appropriate.

**Frequency of Verification:**

Prior to/at the time of contract and every 12 months thereafter.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Nutritional Counseling**

**Provider Category:**

Individual ▾

**Provider Type:**

Registered Dietitian

**Provider Qualifications**

**License (specify):**

California Code of Regulations (CCR), Business and Professions Code, Division 2, Chapter 5.65  
Section 2585-2586.8

Credentialed by the American Dietetic Association

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Project Director at the AIDS Waiver Agency

**Frequency of Verification:**

Prior to/at the time of employment.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▾

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

**Service Title:**

Psychotherapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

**Service Definition (Scope):**

The Psychotherapist provides ongoing therapy to AIDS Waiver participants with regard to the psychological adjustment to living with HIV/AIDS. The Psychotherapist may also provide therapy to caregivers of AIDS Waiver participants with end-stage AIDS. This service may be provided with or without the participant present. Providing this service will help prevent caregiver burnout and decreases in effectiveness, improve caregiver performance, and assist caregivers in coping with the AIDS Waiver participant's impending death. Individuals providing psychotherapy services may not be the participant's qualified case manager or perform administrative activities.

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

Psychotherapy services will be paid for based on a maximum hourly rate. The frequency and need for services will be determined by the qualified SW case manager.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Marriage and Family Therapist
Individual	Clinical Psychologist
Individual	Licensed Clinical Social Worker (LCSW)
Individual	Master's Degree Nurse: Psychiatric & Mental Health Clinical Nurse Specialist or Psychiatric & Mental Health Nurse Practitioner

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

Service Type: Other Service  
Service Name: Psychotherapy

Provider Category:

Individual ▾

**Provider Type:**

Marriage and Family Therapist

**Provider Qualifications****License (specify):**

CCR Title 16, Division 18 and BPC Chapter 13, Article 1-7, Sections 4980-4989

**Certificate (specify):**

**Other Standard (specify):**

CDPH/OA may provide an exemption to an AIDS Waiver Agency if an individual cannot be contracted for this service and the AIDS Waiver Agency has a qualified individual who can provide the service.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Consumer Affairs, Board of Behavioral Sciences

Project Director at the AIDS Waiver Agency

**Frequency of Verification:**

Every two years

Prior to/at time of employment

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Psychotherapy****Provider Category:**

Individual ▾

**Provider Type:**

Clinical Psychologist

**Provider Qualifications****License (specify):**

CCR, Title 16, Division 13.1 and BPC, Chapter 6.6, Section 2903

**Certificate (specify):**

**Other Standard (specify):**

Master's degree from an Accredited School of Psychology

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Consumer Affairs, Board of Psychology

Project Director at the AIDS Waiver Agency

**Frequency of Verification:**

Every two years

Prior to/at time of employment

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Psychotherapy**

**Provider Category:**

Individual ▾

**Provider Type:**

Licensed Clinical Social Worker (LCSW)

**Provider Qualifications**

**License (specify):**

CCR, Title 16, Division 18 and Business and Professions Code (BPC) Division 2, Chapter 14, Articles 1-4, Sections 4990-4998.7

**Certificate (specify):**

**Other Standard (specify):**

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Consumer Affairs, Board of Behavioral Sciences

Project Director at the AIDS Waiver Agency

**Frequency of Verification:**

Every two years

Prior to/at time of employment

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Psychotherapy**

**Provider Category:**

Individual ▾

**Provider Type:**

Master's Degree Nurse: Psychiatric & Mental Health Clinical Nurse Specialist or Psychiatric & Mental Health Nurse Practitioner

**Provider Qualifications**

**License (specify):**

California Code of Regulations (CCR), Title 16, Section 1409, Nursing Practice Act, Division 2, Chapter 6, Article 1, Section 2732

**Certificate (specify):**

**Other Standard (specify):**

Accredited School of Counseling.

The AIDS Waiver Agency provides this service directly when an exemption has been approved by CDPH/OA.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Project Director at the AIDS Waiver Agency

**Frequency of Verification:**  
Prior to/at time of employment

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service 

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

**Service Title:**

Skilled Nursing, Licensed Vocational Nurse

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Skilled nursing services consist of:

- Assessing and assisting in evaluating participants' nursing needs related to specific skilled home care;
- Implementing the home health agency nursing PCSP;
- Performing treatments and instituting preventive procedures in accordance with the plan of treatment or the PCSP that require the special skills of a nurse, as ordered by their primary care provider and/or as authorized by the qualified case manager;
- Performing rehabilitative procedures, as appropriate, that are required for the safety and care of the participant;
- Monitoring participant symptoms and reporting change/participant needs to treating provider and the qualified case manager;
- Counseling and instructing the participant and family about nursing and related needs; and
- Preparing clinical assessment and progress notes related to the above functions.

In addition to the above mentioned skilled nursing services, the Licensed Vocational Nurse may also provide the following services:

- Provision of basic hygienic and nursing care;
- Measurement of vital signs;
- Basic participant assessment (collection of information, not interpretation of information);
- Participates in planning;
- Executes interventions in accordance with the PCSP or plan of treatment;
- Contributes to evaluation of individualized interventions related to the PCSP or plan of treatment;
- Documentation;
- Performance of prescribed medical treatments;
- Administration of prescribed medications;
- Performance of non-medicated intravenous therapy and blood withdrawal (requires separate Board certification);
- Applies communication skills for the purpose of patient/participant care and education; and
- Contributes to the development and implementation of a teaching plan related to self-care for the AIDS Waiver participant.

LVN services are provided when nursing services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the State Plan. The provider qualifications specified in the State Plan apply. The additional amounts of services that may be provided through the AIDS Waiver also include: (1) end-stage continuous short-term care for participants not electing the hospice benefit, and (2) continuous care situations (State Plan is primarily for intermittent care).

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

LVN services will be paid for based on 15 minute increment rate and the frequency and need for services will be determined by the qualified case manager. State Plan services will be used when available.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Waiver Agency with Exemption Approved by CDPH/OA

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Skilled Nursing, Licensed Vocational Nurse**

**Provider Category:**

Agency ▼

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** (*specify*):

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725

**Certificate** (*specify*):

N/A

**Other Standard** (*specify*):

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Must provide basic training on HIV/AIDS, infection control, and confidentiality.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CDPH Licensing and Certification and the AIDS Waiver Agency Project Director.

**Frequency of Verification:**

Prior to/at time of contract and every 12 months thereafter.

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Skilled Nursing, Licensed Vocational Nurse

**Provider Category:**

Agency

**Provider Type:**

AIDS Waiver Agency with Exemption Approved by CDPH/OA

**Provider Qualifications**

**License** (*specify*):

Business and Professions Code Sections 144, 480-487, 492, 493, 496, 810, 820-828, 2866, and 2872.1.

**Certificate** (*specify*):

**Other Standard** (*specify*):

CDPH/OA approved exemption.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AIDS Waiver Agency Project Director and CDPH/OA

**Frequency of Verification:**

Prior to/at time of hire and every 12 months thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Skilled Nursing, Registered Nurse

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

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

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

**Service Definition (Scope):**

Registered Nurse services consist of:

- Assessing and evaluating participants' nursing needs related to specific skilled home care;
- Developing and implementing the home health agency nursing PCSP;
- Evaluating and treating ailments and instituting preventive procedures that require the special skills of a nurse, as ordered by a provider and/or as authorized by the qualified case manager;
- Performing rehabilitative procedures, as appropriate, that are required for the safety and care of the AIDS Waiver participant;
- Monitoring AIDS Waiver participant symptoms and reporting change/participant needs to treating provider and the qualified case manager;
- Counseling and instructing the AIDS Waiver participant and family about nursing and related needs; and
- Preparing clinical assessment and progress notes related to the above functions.

In addition to the above mentioned skilled nursing services, the Registered Nurse may also provide the following services:

- Medication management;
- Drawing insulin;
- Injections; and
- Dressing changes.

Services are provided when nursing services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the State Plan. The provider qualifications specified in the State Plan apply. The additional amounts of services that may be provided through the AIDS Waiver also include: (1) end-stage continuous short-term care for participants not electing the hospice benefit, and (2) continuous care situations (State Plan is primarily for intermittent care).

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

Services will be paid for based on a 15 minute increment rate and the frequency and need for services will be determined by the qualified case manager. State Plan services will be used when available.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Waiver Agency with an Exemption Approved by CDPH/OA

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing, Registered Nurse

Provider Category:

Agency ▼

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

CCR, Title 22, Division 5, Section 74652(c), Health & Safety Code, Section 1725

Certificate (specify):

N/A

Other Standard (specify):

As specified in the California Department of Social Services Manual of Policies and Procedures, Division 30, Chapter 30-757.

Must provide basic training on HIV/AIDS, infection control, and confidentiality.

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH Licensing and Certification and the AIDS Waiver Agency project director.

Frequency of Verification:

Prior to/at time of contract and every 12 months thereafter.

## Appendix C: Participant Services

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

Service Type:

Service Name:

Provider Category:

▼

Provider Type:

Provider Qualifications

License (specify):

Certificate (specify):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

- Not applicable** - Case management is not furnished as a distinct activity to AIDS Waiver participants.
- Applicable** - Case management is furnished as a distinct activity to AIDS Waiver participants.

*Check each that applies:*

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*

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

## Appendix C: Participant Services

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### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Registered Nurse, Psychiatric/Mental Health Nurse Specialists, Licensed Vocational Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist and Psychologists:  
The Department of Consumer Affairs (DCA) conducts criminal history/background screening record clearance as a condition of initial certification and recertification. DCA denies, suspends, or revokes the application or recertification of individuals who do not pass criminal history/background screenings. DCA uses live scan technology to

electronically transmit fingerprints directly to the Department of Justice (DOJ). DOJ checks the fingerprints against their records and sends file information to the Federal Bureau of Investigation for review. Citations: Business and Professions Code Sections, 144, 480-487, 492, 493, 496, 810, 820-828, 2750-2765, 2795-2796, 2866, 2872.1, 2914-2915, 4980-4989, 4990-4998, and Penal Code Section 11105, subd. (b)(10).

**Certified Home Health Aide and Certified Nurse Assistant:**  
CDPH Licensing & Certification (L&C) conducts criminal history screening clearances as a condition of initial certification and recertification. CDPH L&C denies, suspends, or revokes the application or certificate of individuals who do not pass criminal history/background screenings. CDPH L&C electronically transmits fingerprints directly to DOJ using live scan technology. Home Health Agencies must consult the abuse registry prior to hiring direct care staff and implement a system to ensure only currently licensed individuals are employed. Citations: Health and Safety Code Sections 1728.1, 1728.2, 1736.4, 1736.5(a), 1736.6.

**Registered Dietitian:**

The Commission on Dietetic Registration (CDR) registers dietitians for five years with annual renewal requiring completion of 75 units of continuing professional education and re-registration. Citations: Business and Professions Code Sections 2585 and 2586.

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

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

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

**Registered Nurse, Psychiatric/Mental Health Nurse Specialists, Licensed Vocational Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist, and Psychologists:**  
DCA conducts abuse screening record clearance as a condition of initial certification and recertification. DCA denies, suspends, or revokes the application or recertification of individuals convicted. Citations: Business and Professions Code Sections, 144, 48-487, 492, 493, 496, 810, 820-828, 2750-2765, 2795-2796, 2866, 2872.1, 2914-2915, 4980-4989, 4990-4998, and Penal Code Section 11105, subdivision B.

**Certified Home Health Aide and Certified Nurse Assistant:**

CDPH L&C conducts background checks and abuse screening clearances as a condition of initial certification and semi-annual recertification. CDPH L&C denies, suspends, or revokes the application or certificate of individuals convicted. Citations: Health and Safety Code 1736.1, 1736.2, 1736.7.

## Appendix C: Participant Services

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

**c. Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:**

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

**i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Care Facilities for the Chronically III --(RCF-CI)	
Foster Family Homes (Specialized)	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Many RCF-CIs specialize in solely housing persons with HIV/AIDS and may have smaller capacities than allowed by regulation. They are home-like environments housing one to two people per bedroom and bathroom. Participants have full access to the home, such as kitchen/cooking facilities, a small dining area, family-like common areas as well as privacy as needed, easy access to resources, and community and in-house activities.

For participants receiving services in RCF-Cis, the person-centered planning team must determine that the setting is appropriate to the individual’s need for independence, choice and community integration. The person-centered process is always used to choose the services and settings and determine if the setting is appropriate to meet the individual’s needs and choices. The determination 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 by the individual 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 (if individuals choose to share a residence, visitors are allowed at any time, recognizing the rights of their roommates; e) use the telephone with privacy; f) choose how and with whom to spend free time; and g) individuals can schedule and 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.

Residents are informed of their rights, including the right of freedom from coercion and restraint, upon moving into a licensed residential setting. Additionally, a statement of these rights is posted in the home, including contact information if the individual believes his or her rights have been violated. Also, periodic monitoring and evaluation conducted by regional centers and licensing entities includes verification that personal rights are protected.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Residential Care Facilities for the Chronically III --(RCF-CI)

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	<input type="checkbox"/>

Waiver Service	Provided in Facility
Home-Delivered Meals / Nutritional Supplements	<input type="checkbox"/>
Medi-Cal Supplements for Infants and Children in Foster Care	<input checked="" type="checkbox"/>
Psychotherapy	<input type="checkbox"/>
Attendant Care	<input checked="" type="checkbox"/>
Skilled Nursing, Licensed Vocational Nurse	<input checked="" type="checkbox"/>
Enhanced Case Management	<input checked="" type="checkbox"/>
Skilled Nursing, Registered Nurse	<input checked="" type="checkbox"/>
Non-Emergency Medical Transportation	<input checked="" type="checkbox"/>
Homemaker	<input type="checkbox"/>
Nutritional Counseling	<input checked="" type="checkbox"/>

**Facility Capacity Limit:**

25

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

N/A

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Foster Family Homes (Specialized)

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Home-Delivered Meals / Nutritional Supplements	<input type="checkbox"/>
Medi-Cal Supplements for Infants and Children in Foster Care	<input checked="" type="checkbox"/>
Psychotherapy	<input type="checkbox"/>
Attendant Care	<input checked="" type="checkbox"/>
Skilled Nursing, Licensed Vocational Nurse	<input checked="" type="checkbox"/>
Enhanced Case Management	<input checked="" type="checkbox"/>
Skilled Nursing, Registered Nurse	<input checked="" type="checkbox"/>
Non-Emergency Medical Transportation	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Nutritional Counseling	<input checked="" type="checkbox"/>

**Facility Capacity Limit:**

2

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

Foster Family Homes do not have staff-to-resident ratios since no more than two children may reside in a foster family home that specializes in caring for children with HIV/AIDS.

The foster parent(s) provides care and supervision to the foster child/children. (Health and Safety Code Section 1507.5(a))

For participants receiving services in Foster Family Homes, the person-centered planning team must determine that the setting is appropriate to the individual's need for independence, choice and community integration. The person-centered process is always used to choose the services and settings and determine if the setting is appropriate to meet the individual's needs and choices. The

determination 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 by the individual 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 (if individuals choose to share a residence, visitors are allowed at any time, recognizing the rights of their roommates; e) use the telephone with privacy; f) choose how and with whom to spend free time; and g) individuals can schedule and 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.

Residents are informed of their rights, including the right of freedom from coercion and restraint, upon moving into a licensed residential setting. Additionally, a statement of these rights is posted in the home, including contact information if the individual believes his or her rights have been violated. Also, periodic monitoring and evaluation conducted by regional centers and licensing entities includes verification that personal rights are protected.

## Appendix C: Participant Services

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

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

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

CDPH/OA requires AIDS Waiver Agencies to establish and implement policies and procedures assuring that all willing and qualified providers have the opportunity to enroll as AIDS Waiver service providers. AIDS Waiver Agencies must subcontract with a sufficient number of service providers to allow participants a choice of at least three providers for each service, when possible, and with other qualified providers desired by the participant. In compliance with Section 1902(a)(23) of the Social Security Act, AIDS Waiver participants are given the choice of any qualified provider who agrees to furnish the services. CDPH/OA monitors this requirement during program compliance reviews and in semi-annual progress reports review.

AIDS Waiver Agencies are also required to recruit service providers on an ongoing basis and at least annually. AIDS Waiver Agencies typically recruit service providers by contacting potential community vendors asking if they would be interested in providing their services to AIDS Waiver participants. CDPH/OA staff reviews and discusses provider recruitment efforts with Project Directors during their 24-month program compliance reviews.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of AIDS Waiver licensed/certified providers that meet provider qualifications** Numerator- Number of AIDS Waiver licensed/certified providers that meet the required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services / Denominator- Total number of AIDS Waiver providers.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Personnel Records**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of AIDS Wavier agencies who received approval prior to the provision of AIDS waiver services. Numerator - Number of AIDS Wavier agencies who received exemption from CDPH/OA to provide direct care waiver services prior to the provision of the waiver services / Denominator - Total number of waiver agencies providing direct care waiver services.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**On-site review of vendor files**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
		<input type="checkbox"/> Other

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

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

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

- c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

**Performance Measure:**

**#/% of AIDS Waiver service providers who provide appropriate training to providers**  
**Numerator - Number of AIDS Waiver service providers who provide training to persons providing skilled nursing, homemaker, attendant care services prior to provision of services / Denominator - Total number of AIDS Waiver service providers that provide skilled nursing, homemaker and attendant care services**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
CDPH/OA works collaboratively with the AIDS Waiver Agency’s Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the AIDS Waiver Agency during the exit conference, and a formal written Summary of Findings is provided to the AIDS Waiver Agency following the review. The AIDS Waiver Agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the AIDS Waiver Agency appropriately addresses the findings.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No  
 Yes

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

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

- Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

1. Home/minor physical adaptations combined with specialized medical equipment and supplies are limited to \$1,000 per AIDS Waiver participant per calendar year. Most medical supplies and equipment are covered in the State plan, and physical adaptations are a "by request" item in the State plan. Except in unusual circumstances, the \$1,000 limit covers items/costs not covered by the State plan. The limit for this service is based on historical costs and utilization. AIDS Waiver Agencies have other resources to help meet this need, should it occur.

2. The limit for spending on nutritional supplements is combined with the limit on spending for home delivered meals and amounts to \$150 per participant per month. This limit is based on historical costs and utilization. The \$150 AIDS Waiver limit has historically met participants' needs since there are many alternative resources for free or discounted cost meals. Nutritional supplements and home delivered meals are not covered in the State plan.

3. Foster Care Financial supplement: \$338 per participant/per month.

This limit has historically met participants' needs since there are alternative resources for financial supplements.

4. Non- Emergency Medical Transportation: \$40 per participant/per month

This limit has historically met participants' needs since there are alternative resources for transportation.

5. Annual participant costs: \$13,209 per participant/per calendar year.

This limit is based on historical utilization/cost patterns. The calendar year costs limit for participants is lower than the average per capita for institutional participants.

A qualified case manager discusses these limits with each participant at the time of enrollment and when these services are authorized in the participant centered service plan.

These limits are based on historical utilization/cost patterns. When annual participant costs are reached, participants are disenrolled from the AIDS Waiver and transitioned to another funding source such as Ryan White to cover applicable expenditures.

CDPH/OA and DHCS LTCD may conduct studies to determine if the amount of the aforementioned limits needs to be adjusted. The methods employed to make such determinations shall be objective, evidence-based, and applied consistently statewide.

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

*Furnish the information specified above.*

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

*Furnish the information specified above.*

- Other Type of Limit.** The State employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

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

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

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Comprehensive Service Plan (CSP)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**  
 **Licensed practical or vocational nurse, acting within the scope of practice under State law**  
 **Licensed physician (M.D. or D.O)**  
 **Case Manager** (qualifications specified in Appendix C-1/C-3)  
 **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

- Social Worker**

*Specify qualifications:*

- Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**  
 **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

AIDS Waiver participants are involved in every aspect of the service plan development. Prior to enrollment, a qualified case manager describes waiver services, limitations, requirements, and any feasible alternative programs and supports to the applicant. He/she also provides information about rights, responsibilities, grievance procedures, and requesting a State Fair Hearing to the applicant. AIDS Waiver participants and others they choose to be involved, e.g., family or legal representative, are actively involved in the decision-making process regarding the provision of services to the AIDS Waiver participant.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

A) Who Develops, Who Participates In, and Timing of the PCSP:

AIDS Waiver Agency's nurse case manager, social work case manager, and participant collaborate to develop a PCSP which addresses the participant's needs, goals and preferences. The PCSP must be initiated at the time of enrollment and prior to delivery of AIDS Waiver services. The PCSP is reviewed at least every 180 days, and updated on an ongoing basis if participant's needs are assessed to change. The PCSP development also takes into account participant input from the interdisciplinary team as appropriate.

The interdisciplinary team consists of the participant and/or his/her legal representative, primary care provider, and the parent or guardian if the participant is a child.

The PCSP identifies the participant's service needs (as documented in the face-to-face comprehensive participant assessment/reassessments and progress notes as appropriate), and the services to be provided to that participant (including informal supports that complement AIDS Waiver services). All services that a participant will receive must be identified in the PCSP, regardless of funding source. AIDS Waiver services must be specified by type, amount, duration, scope, and frequency before provision of services.

B) Types of Assessments Conducted to Support the PCSP:

Nursing Assessment:

A comprehensive medical review conducted by the qualified nurse case manager on or within 15 days prior to enrollment and reassessments at least every 180 days thereafter. The review includes screening and/or assessing the following:

- Vital signs;
- Physical exam;
- Comprehensive systems review;
- Pertinent physiological information;
- Level of orientation;
- Cultural information;
- Current health status and habits;
- Need for and availability of caregivers;
- Transmission prevention (safe/safer sex, needle sharing, harm reduction techniques);
- Medications and known or increasing side effects;
- Complimentary or alternative therapies;
- Adherence to medication regimen;
- Barriers to adherence;
- Health history;
- Nutritional assessment;
- Risk assessment and mitigation;
- Summary of findings and plan for next 180 days: and
- Certification of Nursing Facility Level of Care.

Psychosocial Assessment:

Conducted by the qualified social work case manager on or within 15 days prior to enrollment and reassessments at least every 180 days. The review includes an assessment of the following:

- Family and support systems;
- Coping strategies;
- Strengths and weaknesses;

- Adjustment to illness;
- Education;
- Cultural factors;
- Legal issues (legal history, wills, Durable Power of Attorney and/or Durable Power of Attorney for Healthcare);
- Funeral arrangements;
- Substance use/abuse history and current risk behaviors;
- Resources and needs in regards to food, housing, and transportation;
- Finances;
- Transmission prevention (safe/safer sex, needle sharing, harm reduction techniques);
- Risk assessment and mitigation; and
- Summary of findings and plan for the qualified case manager for the next 180 days.

Resource Evaluation:

Conducted by the qualified case manager on or within 15 days prior to enrollment and reassessments at least every 180 days. This is a screening of benefits and/or entitlements a participant may be receiving or is potentially eligible for. The following is assessed:

- Private medical insurance;
- Medicare;
- Medi-Cal managed care;
- Medi-Cal;
- AIDS Drug Assistance Program (ADAP);
- California children services (for children only); and
- In Home Support Services (IHSS).

Home Environment Assessment:

Conducted by the qualified case manager or other AIDS Waiver staff within 30 days of enrollment with reassessments conducted at least once a year and when the participant moves. The review includes an assessment of the following:

- Structural integrity;
- Availability of adequate heating and cooling system;
- Electricity;
- Gas;
- Hot and cold running water;
- Food storage and preparation facilities;
- Basic furnishings;
- Cleanliness;
- Presence of hazards;
- Functional plumbing;
- Telephone services;
- Laundry facilities; and
- Care of pets (if any).

C) How the participant is informed of the services that are available under the AIDS Waiver:

When an individual is interested in participating in the AIDS Waiver, a qualified case manager describes the services, limitations and requirements of the AIDS Waiver and any feasible alternative programs to him/her. The qualified case manager answers any program questions the individual has. All applicant questions are to be resolved by the qualified case manager prior to enrollment and development of the PCSP.

D, E, & F) PCSP Process:

Participant Goals, Needs, Preferences; Service Coordination; Implementation; and Monitoring.

Qualified case managers utilize the baseline information from the comprehensive participant assessments to develop the initial PCSP. The PCSP includes, but is not limited to, the following elements:

- Long-Term Goals: One or more brief statements expressing the primary reason(s) for the participant's enrollment

in the program and the purpose for the provision of case management services.

- **Identified Problems or Needs:** A brief statement of the problem or need identified by the participant, and qualified case manager during the assessment, reassessment, or through other contact with the participant and interdisciplinary team. Documentation of the assessments must support or describe the identified problem or need in more specific detail.
- **Stated Goals/Objectives:** The stated goals and objectives must include the desired outcome. The outcome should address the resolution or management of the identified problem or need.
- **Services and Interventions:** A brief description of the services the participant is receiving, or will receive, which addresses the identified problem or need, and whose aim is to meet the stated goals and objectives. This includes: the service/type of provider, frequency, quantity, and duration of the service (e.g. attendant care, XYZ Home Health Agency, four hours per day, twice weekly, for two months).
- **Payment source** for the stated services and interventions.
- **Initials and signature** of the qualified case manager developing the PCSP and each update.
- **Participant signature and date** signed on initial PCSP and each update.
- **Date** problem or need was identified and the start date for services/interventions.
- **Documentation** that the Primary Care Provider has been notified of the contents of the initial PCSP.
- **Documentation** that the participant or his/her legal representative has had input regarding the contents of the initial PCSP and updates, including needs, goals, and preferences.

Cost Avoidance:

- All other available resources are screened for and accessed prior to utilization of waiver funds when arranging participant's services/interventions.
- AIDS Waiver Agency staff document cost avoidance activities in the participant's chart each time they occur.
- Documentation covers what agencies/resources were accessed, what services were requested, and why services could not be provided.

G) PCSP Reviews, Updates, and Revisions:

- The PCSP is reviewed, updated and revised as problems and/or service needs change.
- Any updates or revisions to the PCSP shall include the same required elements which applied to the original PCSP.
- At least every 180 days, the case managers review all components of the PCSP including input from participant and/or legal representative.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

AIDS Waiver qualified case managers conduct face-to-face comprehensive assessments and reassessments of all participants. Potential risks to the participants are assessed during assessments, monthly face-to-face contacts, and as needed. Risk areas assessed include home environment, health, falls, nutrition, self-care, financial, medications, cognition, emotional, activities of daily living, abuse, neglect, exploitation, personal safety, resources, mental health, wellness, and behavior. Qualified case managers use this information and obtain participant and/or family/representative input when developing the PCSP.

Qualified case managers assure the health and welfare of AIDS Waiver participants by ensuring that the participant is receiving appropriate services and supports. The PCSP indicates who is responsible for providing each service. The case managers monitor the PCSP services furnished by providers outside of the AIDS Waiver Agency providers. The PCSP is reviewed with the participant at least every 180 days during reassessments. Strategies to mitigate participant risk, including supports other than AIDS Waiver services, are incorporated in the PCSP and are tailored to each participant's needs and preferences.

Each AIDS Waiver Agency shall develop and implement policies and procedures to ensure continuity in the provision of enhanced case management services during expected and unexpected absences of case management staff. AIDS Waiver Agencies shall review their policies and procedures annually and revise as necessary. CDPH/OA shall review these policies and procedures every 24 months during AIDS Waiver Program Compliance Reviews.

Each AIDS Waiver Agency and the agencies with whom they subcontract shall develop and maintain backup service plans for the provision of services during the absence of direct care service providers. CDPH/OA shall monitor AIDS Waiver agencies' compliance regarding backup service plans.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

To ensure that participants have choice of providers, AIDS Waiver Agencies are required to offer, when possible, at least three providers from each service category.

During PCSP development, case managers provide participants with information on available providers, and discuss participant's preferences and choice of service providers.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

AIDS Waiver Agencies use the PCSP form and PCSP Attachment A. CDPH/OA staff review and discuss the requirements with the Project Director during the 24-month Program Compliance Review and provides feedback and/or technical assistance as necessary. LTCD shall work collaboratively with and/or independently of CDPH/OA to ensure compliance with state and federal regulations, Medicaid statutes, the interagency agreement between DHCS and CDPH, and AIDS Waiver requirements ensure the PCSP is approved in accordance with 42 CFR §441.301 (b)(1)(i).

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

*Specify the other schedule:*

180 days or more frequently when necessary

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

- Medicaid agency  
 Operating agency  
 Case manager  
 Other

*Specify:*

As part of their agreement with CDPH/OA, AIDS Waiver Agencies must maintain each participant's service record, including electronic or hard copies of PCSPs, during enrollment in the AIDS Waiver and for a minimum of three years after the participant's case is closed. AIDS Waiver Agencies must be Health Insurance Portability & Accountability Act (HIPAA) compliant and follow accepted guidelines for record handling and documentation practices for health care records.

AIDS Waiver Agencies must keep active participant records onsite in locked storage areas (protected from potential damage and/or unauthorized access) which are accessible only by AIDS Waiver Agency staff directly responsible for filing, charting, and review, and to State and federal representatives as required by law. No documents shall be destroyed or removed from a record once entered. Each AIDS Waiver Agency shall establish a plan for the storage and retrieval of records in the event of closure. All AIDS Waiver Agencies policies must address how records are to be stored, removed and destroyed three years following the final payment of the agreement, be HIPAA compliant, and follow accepted guidelines for record handling and documentation for health care records.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **D-2: Service Plan Implementation and Monitoring**

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

The AIDS Waiver participant's nurse and social work case managers shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member, and to ensure that the PCSP is effectively implemented and adequately addresses the needs of the participant.

At the minimum, the case managers will each make face-to-face contact with the participant at least monthly. This contact must be documented in the progress notes, and changes made to PCSP as appropriate.

In addition, an interdisciplinary team case conference (IDTCC) is held for each participant at least every 180 days. The team consists of the participant and/or his/her legal representative, the qualified case managers, and the parent or guardian (if the participant is a child), The Project Director, and other service providers involved. The primary care provider(s) may also participate.

If service providers are unable to attend, information regarding the participant's status and continued need for services shall be collected by the nurse case manager and/or social work case manager prior to the case conference who will present the information at the IDTCC, as appropriate.

If the participant or his/her legal representative is unable to attend, the participant or his/her legal representative input is gathered during reassessments and other contacts with the qualified case manager.

During the IDTCC, qualified case managers address the medical, psychosocial, housing, and financial needs of each participant and how his/her PCSP seeks to address these needs in the coming months. The qualified case manager review the PCSP, evaluate the services the participant is receiving, review the participant's current status, discuss any changes in the participant's status and the length of time the participant is anticipated to be on the AIDS Waiver with the participant. The qualified case manager documents the following information in each participant's chart: the names, licenses and/or degrees and titles of those attending the conference, relevant information discussed, and

whether the participant or his/her legal representative had input in the conference.

Each AIDS Waiver Agency must have policies and procedures for protecting participant confidentiality during the IDTCCs.

**b. Monitoring Safeguards.** *Select one:*

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of records reviewed that had PCSP which included participant input addressing all individualized goals**  
**Numerator - Number of records reviewed that document participant input into PCSP/**  
**Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> State Medicaid Agency		
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size
	<input checked="" type="checkbox"/> Other Specify: Biennially	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of records reviewed that had PCSP which addressed all participants' assessed needs including health and safety risk factors**  
**Numerator - Number of charts reviewed with PCSP that addressed all participants assessed needs including health and safety / Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size
	<input checked="" type="checkbox"/> Other Specify: Biennially	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of PCSPs updated/revised at least every 180 days Numerator - Number of PCSPs updated /revised at least every 180 days/ Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<input type="text" value=""/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

#/% of waiver participants' records reviewed whose PCSPs were revised as warranted by changes in the participants' needs  
 Numerator - Number of waiver participants' records reviewed whose PCSPs were revised as warranted by changes in participant's needs documented in the participant's chart /  
 Denominator - Total number of charts reviewed with PCSPs that needed revision (prior to 180 days)

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how*

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

#/% of Waiver participants who received services in the type, scope, amount, duration, and frequency as specified in the PCSP as verified by Waiver participant attestation. Numerator - Number of waiver participant's records reviewed who received services in the type, scope, amount, duration and frequency as specified in the PCSP / Denominator - Total number of charts reviewed

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size
	<input checked="" type="checkbox"/> Other Specify: Biennially	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of PCSPs reviewed with documentation that participant was offered a choice among waiver services and available providers. Numerator - Number of PCSPs reviewed with documentation that participant was offered choice among waiver services and available providers / Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b>

Specify: <input style="width: 100%; height: 20px;" type="text"/>		Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

N/A

**b. Methods for Remediation/Fixing Individual Problems**

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

CDPH/OA works collaboratively with the AIDS Waiver Agency’s Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the AIDS Waiver Agency during the exit conference, and formal written Summary of Findings is provided to the AIDS Waiver Agency following the review. The AIDS Waiver Agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the AIDS Waiver Agency appropriately addresses the findings.

- ii. **Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No  
 Yes

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

## **Appendix E: Participant Direction of Services**

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**Applicability** (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.  
 **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**  
 **No. Independence Plus designation is not requested.**

## **Appendix E: Participant Direction of Services**

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### **E-1: Overview (1 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix E: Participant Direction of Services**

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**E-1: Overview (2 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (3 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (4 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (5 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant Direction (1 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

---

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

---

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

---

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix F: Participant Rights**

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**Appendix F-1: Opportunity to Request a Fair Hearing**

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

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice

(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

State law, Medi-Cal regulations, and federal regulations (WIC 10950, California Code of Regulations, Title 22, Section 51014.1 and the intent of Code of Federal Regulations, Title 42, Chapter IV, Section 431.220) require that AIDS Waiver Agency agencies provide a copy of standard form, Notice of Action Denial/Discontinuance and State Hearing Notice Request, Your Right to Appeal the Notice of Action to all applicants at initial application and to all existing participants when they are: (1) not given the choice of home and community-based services as an alternative to institutional care; (2) denied the service(s) of their choice or the provider(s) of their choice; (3) dispute the denial, suspension, reduction or termination of one or more services; or (4) terminated/disenrolled from the AIDS Waiver.

The Notice of Action (NOA) includes information about the:

- (1) Process for requesting a State Fair Hearing (SFH), including the assistance available to persons pursuing a Fair Hearing, and
- (2) Requirement that AIDS Waiver Agency must continue providing services to participants who have submitted requests for State Fair Hearings while their requests are being addressed, provided the participants' requests are submitted within 10 days of the mailing or personal delivery of the notice of action.

Each AIDS Waiver Agency shall maintain a copy of each participant's completed NOA and supporting documents in each participant's file.

The California Department of Social Services (CDSS), State Hearings Division is the entity designated to conduct SFH. During a SFH, a participant may represent him/herself or can be represented by a friend, attorney, or any other person, but must arrange for his/her own representative(s). SFHs are held in the county where the petitioning participant lives. If the participant is unable to attend the hearing at the designated hearing location for reasons of poor health, the hearing may be held in the participant's home, by telephone or in another appropriate setting.

Attendance at the hearing is ordinarily limited to the participant, participant witnesses relevant to the issue, and authorized representative and/or interpreter, if any, and normally no more than two persons from the AIDS Waiver Agency. A CDSS Administrative Law Judge shall prepare a Final Decision for AIDS Waiver SFH.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Continually, CDPH/OA reviews all information submitted by AIDS Waiver Agency or any other sources regarding participant complaints and grievances, and instances of abuse, neglect, and exploitation. The agreements between CDPH/OA and AIDS Waiver Agency require AIDS Waiver Agency to implement and maintain written grievance policies and procedures describing the submission, documentation, evaluation, and resolution of all participant grievances.

AIDS Waiver Agency design policies and procedures that fit their unique structures and the participants they serve. Grievance policies and procedures are subject to review and approval by CDPH/OA staff during program compliance reviews and as necessary. CDPH/OA staff consults AIDS Waiver Agency on handling complaints, grievances, and complicated situations. AIDS Waiver Agency report in their bi-annual progress reports any

complaints and grievances and their outcomes. Medi-Cal SFHs serve as an additional dispute resolution method for participants. A participant's right to receive a SFH is still preserved if a participant elects to make use of the grievance process. Participants shall be informed that the employment of the additional dispute resolution mechanism does not serve as a prerequisite or substitute for a SFH.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

CDPH/OA.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

AIDS Waiver Agencies must maintain and implement policies and procedures which describe the receipt/reporting, documentation, evaluation, and resolution of grievances. Grievances are categorized into verbal complaints and written complaints.

A verbal complaint consists of any expression of dissatisfaction by a participant to AIDS Waiver Agency staff in person or by telephone. For example, a participant may verbally complain that his/her qualified case manager does not return phone calls in a timely manner. Verbal complaints are responded to verbally by AIDS Waiver Agency staff and are usually resolved quickly.

A written complaint is considered to be a formal complaint and consists of any written expression of dissatisfaction by a participant to AIDS Waiver Agency staff. Although some AIDS Waiver Agencies design forms for participants to use when submitting written complaints, use of these forms is not obligatory. When written complaints are received, AIDS Waiver Agency staff must document them in the agency's complaint log. Different levels of staff may be involved in the written complaint review process.

AIDS Waiver Agencies must provide written assurances that any participant who requests or needs assistance with the submission of a complaint shall receive it. AIDS Waiver Agency staff presents and reviews these assurances with all participants in the document Participant Rights in Case Management at the time of enrollment and upon request. Upon completing the review of Participant Rights in Case Management, AIDS Waiver Agency staff provides the participant a confirmation of receipt for signature.

All AIDS Waiver Agency grievance policies and procedures must be provided at the time of enrollment and upon request, and must address/include the following:

- A description of the process and general timelines for resolution of the complaint within the AIDS Waiver Agency. If a participant requests to have CDPH/OA contact information provided to him/her, his/her request cannot be refused by the AIDS Waiver Agency;
- Information about the AIDS Waiver Agency grievance policies, procedures, and form(s), if applicable, must be provided to the participant at the time of enrollment and upon request, and include telephone numbers for obtaining information on State Fair Hearing appeal rights;
- All grievances must be brought to the attention of the participant's qualified case manager for first-level resolution, and must be presented at the next IDTCC;

- All grievances must be reviewed at the Quality Improvement/Quality Management committee meeting following submission of the grievance. Appropriate action is taken as a result;
- If a verbal complaint cannot be resolved by the participant's qualified case manager, the participant must be asked if he/she wishes to pursue it via a written complaint;
- If a verbal complaint becomes a written complaint, the AIDS Waiver Agency must notify CDPH/OA of the grievance in the subsequent bi-annual progress report and provide CDPH/OA information pertaining to the case. If the grievance is resolved, the AIDS Waiver Agency must notify CDPH/OA of the resolution reached or outcome;
- If a participant is unwilling to substantiate a complaint, or provide details necessary to perform an investigation, the AIDS Waiver Agency is not obligated to continue investigating the complaint and/or seek resolution, and may close the case. The AIDS Waiver Agency shall notify the participant of its decision in writing.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- No. This Appendix does not apply** (*do not complete Items b through e*)  
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

AIDS Waiver Agencies comply with Welfare and Institution Code §15703 – 15705.40, §15750 – 15766 and §16205 – 16208 and California Penal Code §11164 – 11174.9 and report the following critical event and incident information to CDPH/OA via the bi-annual Progress Report:

- Number of instances of abuse, neglect, exploitation or other critical event or incident reported for the reporting period.
- Types of abuse, neglect, exploitation, or other critical event or incident, i.e., physical, sexual, abandonment, isolation, abduction, financial, neglect, and self-neglect.
- Action(s) taken:  
For children, AIDS Waiver Agencies must report the incident by telephone immediately, or as soon as possible, and in writing within 36 hours of receiving information about the incident, alleged or otherwise. Reports are made to local law enforcement, county probation department, county welfare department, or Child Protective Services (CPS).  
For adults, AIDS Waiver Agencies must report the incident by telephone immediately, or as soon as possible, and in writing within two working days to the appropriate agency. If an incident occurs in a long term care facility, AIDS Waiver Agencies must report it to local law enforcement or the Long Term Care Ombudsman. If an incident occurs in the community, AIDS Waiver agencies must report it to local law enforcement or Adult Protective Services (APS).

- The outcome and/or resolution of events:

CDPH/OA has a system to review reports on critical events and incidents and follows up with the AIDS Waiver Agency to ensure participant health and welfare is protected. As part of the Progress Report review, CDPH/OA Nurse and Social Work Consultant staff review the outcome of any reported incident and what could have been done to mitigate the incident before it occurred and what is being done now to prevent such incidents in the future. CDPH/OA requires AIDS Waiver Agencies to develop policies and procedures regarding Risk Assessment and Mitigation as part of their QI/QM which must be approved by CDPH/OA staff. Follow-up is conducted and technical assistance is given during the routine Program Compliance Review every 24 months. Instance data is analyzed in order to develop strategies to reduce the risk and likelihood of the occurrence of instances in the future and to improve the quality of services provided.

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

At the time of enrollment, the participant/family/caregiver signs the Informed Consent/Agreement to Participate form and receives a copy. This form includes information that AIDS Waiver Agency staff are mandated abuse reporters, and the form provides the participant with information on self-reporting incidents of abuse, neglect and exploitation by calling 911 or contacting their county Adult/Child Protective Services (APS/CPS) office.

When instances of abuse, neglect and/or exploitation occur or are suspected, the AIDS Waiver Agency staff/participant/family/caregiver notifies the appropriate authorities (CPS, APS) by following the AIDS Waiver Agency policies and procedures (P&P) for reporting such instances. CDPH/OA's protocols require that the AIDS Waiver Agency develop P&P regarding reporting of instances. The P&P must include when to report, how to report, and to whom to report. Mandated reporters' responsibilities must also be included in the P&Ps.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

CPS and APS have primary authority over reports of critical events or incidents and may receive these reports from AIDS Waiver Agency staff, family and/or caregivers. CDPH/OA shall review the entire process at the Program Compliance Review every 24 months when reviewing participant charts. CPS and APS conduct investigations according to their own timelines, timeframes and processes for informing necessary parties of the results of any investigations, including the AIDS Waiver Agency, when applicable. Any outcomes of CPS and/or APS investigations shall be reported by AIDS Waiver Agencies on the bi-annual Progress Report to CDPH/OA. CDPH/OA staff shall review the outcomes and follow-up, as warranted.

Each AIDS Waiver Agency shall be responsible for its participants' health and welfare, regardless of any action(s) taken, by CPS/APS.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

CDPH/OA is the State agency responsible for overseeing the reporting of and response to critical incidents and/or events that affect AIDS Waiver participants. CDPH/OA utilizes a process for tracking the reporting, documentation, remediation, and outcome of critical incidents and events which includes the following:

- Qualified case managers shall identify any reported or suspected incidents of abuse, neglect, or exploitation in initial assessment and reassessments. Incidents of abuse, neglect, and exploitation are monitored by CDPH/OA clinical staff during the Program Compliance Review and biannual progress reports to ensure appropriate identification, reporting, and outcome documentation;
- The Program Compliance Review is used to document reported instances of abuse, neglect, and exploitation follow-up, and outcome. CDPH/OA staff shall review all participants' charts which document issues that may affect participants' health and safety and/or which include participant grievances;

- Every AIDS Waiver Agency shall develop, implement, and maintain its own policies and procedures for responding to incidents of abuse, neglect and exploitation. The policies and procedures required by CDPH/OA assure that there are operational procedures for managing incidents at the individual and provider level; that there are procedures in place to assure that incident reports are filed and investigated timely; that key staff are trained; and that incidents data is analyzed in order to develop strategies to reduce the risk and likelihood of the occurrence of incidents in the future and to improve the quality of services provided. These policies and procedures are in addition to what is in the law and shall include provisions from the Welfare and Institutions Code and the Penal Code. These policies and procedures shall include the identification of abuse, types of abuse, who must report, when to report, how to report, to whom one must report, and additional information for mandated reporters. The requirement for development of these policies and procedures are included in the current agreement and have been incorporated in the Protocols and Program Operations Manual forming part of the AIDS Medi-Cal Waiver Program Protocols and they are incorporated in all AIDS Waiver agreements;
- AIDS Waiver Agencies shall submit bi-annual Progress Reports to CDPH/OA and LTCD which include requirements for reporting critical incidents and events, and those critical incidents and events that have occurred during the bi-annual period being reported;
- CDPH/OA shall track data in search of health and welfare issues using the Program Compliance Review database. Areas requiring attention are identified; corrective action is taken; improvements and outcomes are tracked and reported to LTCD; areas requiring attention are reported to LTCD until all areas are resolved;

Bi-annually, CDPH/OA analyzes data to identify trends of critical incidents or events. If identified, CDPH/OA evaluates the trend(s) to determine if changes in program guidance, policy or requirements are necessary. CDPH/OA shall provide regional and/or statewide trainings and follow-up with AIDS Waiver Agencies as necessary.

## Appendix G: Participant Safeguards

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

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

**The State does not permit or prohibits the use of restraints**

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

The AIDS Waiver Agencies are responsible for ongoing monitoring and ensuring the health, safety and welfare of waiver participants including ensuring that restraints are not utilized under any circumstances. The AIDS Waiver case managers will monitor the participant's health and safety at both the monthly face-to-face visits and every 180 days reassessments. CDPH/OA provides oversight during the compliance review process.

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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

**b. Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

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

The AIDS Waiver Agencies are responsible for ongoing monitoring and ensuring the health, safety and welfare of AIDS waiver participants including ensuring that restrictive interventions are not utilized under any circumstances. The AIDS Waiver case managers will monitor the participant's health and safety at both the monthly face-to face visits and every 180 days reassessments. CDPH/OA provides oversight during the compliance review process.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**  
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The State does not permit or prohibits the use of seclusion**

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

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. Applicability.** Select one:

- No. This Appendix is not applicable** (*do not complete the remaining items*)  
 **Yes. This Appendix applies** (*complete the remaining items*)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

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

- c. Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

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

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

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

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

- iii. Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**  
*Complete the following three items:*

- (a) Specify State agency (or agencies) to which errors are reported:

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

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

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

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

**i. Sub-Assurances:**

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

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

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

**Performance Measure:**

**#/% of AIDS Waiver participant records reviewed where the participant received information on how to report abuse, neglect and exploitation**  
**Numerator - Number of AIDS Waiver participant records reviewed where the participant received information on how to report abuse, neglect and exploitation / Denominator - Total number of charts reviewed**

Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size

	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially	
--	--	--

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Biennially

**Performance Measure:**

#/% of AIDS Waiver participant records reviewed that includes documentation that risk for abuse, neglect and exploitation was assessed by the case management team  
 Numerator - Number of AIDS Waiver participant records reviewed that includes documentation that risk for abuse, neglect and exploitation was assessed by the case management team / Denominator - Total number of charts reviewed

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Bi-annual progress reports**

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Bi-annually	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Bi-annually

**Performance Measure:**

**#/% of AIDS Waiver participant records reviewed that included documentation that a Home Environment Assessment was completed in accordance with state waiver program requirements**  
**Numerator - Number of AIDS Waiver participant records reviewed that included documentation that a Home Environment Assessment was completed in accordance with requirements / Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**bi-annual progress reports**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	

		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: bi-annual	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**#/% of waiver participants informed of the Agency Grievance Policy (on Informed Consent / Agreement to Participate) Numerator - Number of waiver participants informed of the Agency Grievance Policy / Denominator - Total number of charts reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 22.11% sample size
	<input checked="" type="checkbox"/> Other Specify: Biennially	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of critical incidents that were reported within the required AIDS Waiver timeframes as documented in the Biannual Progress Reports Numerator - Number of critical incidents that were reported within the required AIDS Waiver timeframes/ Denominator - Total number of critical incidents reported in the Biannual Progress Reports**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Semi-annually for Progress Reports Review; Biennially for chart reviews	

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**#/% of critical incident investigation outcomes reviewed with appropriate follow up documented in the Biannual Progress Reports Numerator - Number of critical incident investigation outcomes reviewed with appropriate follow up documented/ Denominator - Total number of critical incidents reported in the Biannual Progress Reports**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

	<input checked="" type="checkbox"/> <b>Other</b> Specify: Semi-annually for Progress Reports Review; Biennially for chart reviews	
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**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how*

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

The state monitors overall health care standards based on the approved waiver.

**Numerator-** Cases reviewed that meet standards **Denominator-** Total cases reviewed - validated through the Program Compliance Review Process.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
Specify: <input type="text"/>	
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
CDPH/OA works collaboratively with the AIDS Waiver Agency’s Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the AIDS Waiver Agency during the exit conference, and formal written Summary of Findings is provided to the AIDS Waiver Agency following the review. The AIDS Waiver Agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the AIDS Waiver Agency appropriately addresses the findings.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No**  
 **Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

### Quality Improvement Strategy: Minimum Components

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

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services

that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

#### a. System Improvements

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

The California Department of Public Health Office of AIDS (CDPH/OA) performs an ongoing sampling of AIDS Waiver participant records through its discovery process, the Program Compliance Review (PCR). The CDPH/OA compliance review team analyzes case records, progress notes, assessment/reassessments, the PCSP, and any other pertinent documentation. The analysis of these records allows the PCR team to determine that documentation was completed on a timely basis, with the appropriate forms, by appropriate personnel. The areas of review include level of care (LOC), care plan, provider services and participant health and welfare.

When an individual problem is identified during the PCR process, a written report of the findings and recommendations is issued to the site from CDPH/OA that will include a formal written request for a CAP specific to remediating the problem. The AIDS Waiver Agency is required to respond to CDPH/OA with a formal written plan to cover any deficiencies identified within 60 calendar days. The CAP must be specific about the actions to be taken, the personnel who will take the actions, and when the CAP will be completed. The CAP and associated actions are monitored by CDPH/OA and upon successful remediation of the problem the CAP is approved. Technical assistance is provided throughout the process and on an as-needed basis.

Should a specific site have significant issues CDPH/OA would require in writing that the site develop a CAP specific to correcting the issue(s). The site would be required to respond to CDPH/OA with a formal written plan to cover any deficiencies identified within 30 calendar days. The CAP would be specific about the actions to be taken, the personnel who will take the actions, and the completion date of the corrective action. The plan and associated actions would be monitored by CDPH/OA and upon successful remediation of the problem, the CAP would be approved. Technical assistance would be provided throughout the entire issue resolution process.

CDPH/OA aggregates the results of the site PCR discovery information. Aggregate data regarding AIDS Waiver enrollment, Participant Centered Service Plan, trends and significant deficiencies, Summary of Findings Reports, and CAP is reviewed with DHCS/LTCD at quarterly meetings. Policy revisions and updates are disseminated through AIDS Waiver Protocols and Program Operation Manual and through policy clarification letters. CDPH/OA also provides technical assistance through on-going email and telephone contact between the sites and CDPH/OA staff. CDPH/OA uses this aggregate data to prioritize training needs in order to schedule multi-site training events.

#### ii. System Improvement Activities

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of Monitoring and Analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Other</b> Specify:

Responsible Party( <i>check each that applies</i> ):	Frequency of Monitoring and Analysis( <i>check each that applies</i> ):
	Ongoing

## b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The results of PCRs performed after CDPH/OA's remediation activities are analyzed in order to measure their effectiveness. This analysis may result in system changes to the PCRs and PCR tools and to methods of policy dissemination, technical assistance and training.

CDPH/OA analyzes and aggregates the findings from PCRs and ranks the findings according to significance. CDPH/OA staff develops strategies for training and technical assistance, CDPH/OA staff follow-up with site visits after the training is completed to measure efficacy of training.

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

At the next quarterly meeting, both entities compare the results of additional site monitoring from not only the prior quarter, but also during a look-back period mutually agreed upon by both parties depending on the gravity and extent of the trend(s) being identified/validated. If sufficient data have been gathered to make a determination, appropriate steps and system changes are discussed. It is essential that any changes to be made to the quality improvement system (QIS) are incorporated into the CDPH/OA PCR tool.

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

Every 12 months, during the quarterly meeting, preceding the submission of the CMS 372, the effectiveness of existing quality assurance systems are reviewed to determine continued efficacy. System changes are identified and mutually agreed upon between DHCS and CDPH. The PCR tool is changed to reflect mutually agreed upon revisions.

Quality improvement input is also solicited from the AIDS Waiver Agencies during the scheduled collaborative (advisory) teleconferences between CDPH and AIDS Waiver Agencies.

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

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

\* DHCS Financial Audits Branch (FAB) shall ensure the fiscal integrity of the health programs administered by DHCS, its waiver programs and affiliated Departments, to ensure quality of care provided to the beneficiaries of these programs through financial audits and in accordance with applicable laws, regulations, and program intent.

CDPH/OA makes referrals to DHCS LTCD, who in turn, forwards to DHCS A&I requesting that audits of a particular

AIDS Waiver agency be performed if there is a question about fiscal practices at the agency.

#### State Methods to Ensure Integrity of Provider Billings:

In order to claim reimbursement, an agency which chooses to be an organized health care delivery system must first obtain active status from DHCS Provider Enrollment Branch using the CDPH 8545, AIDS Medi-Cal Waiver Program, Medi-Cal Provider Application. Federal regulations require Medicaid programs to ensure program integrity by requiring that providers disclose certain information. The Medi-Cal program attempts to deter potential fraud and abuse by requiring providers to complete the DHCS 6207, Medi-Cal Disclosure Statement form. The provider applicant declares under penalty of perjury under State laws that all information disclosed is true and accurate. The Medi-Cal Provider Enrollment Branch reviews all disclosures. If information disclosed is questionable and believed to result in fraud and/or abuse of Medi-Cal funds, follow-up is made and/or the application is denied. These application forms are submitted via CDPH/OA to the Payment Systems Division, DHCS for processing.

AIDS Waiver Agencies submit participant-related information including level of care (see Appendix B-6) to CDPH/OA. CDPH/OA confirms that participants are Medi-Cal eligible and not currently enrolled in the AIDS Waiver, then issues a participant-specific AIDS Waiver identification number confirming their enrollment. All claims use AIDS Waiver-specific procedure codes.

Medi-Cal pays AIDS Waiver agencies a flat monthly fee for case management services and administrative costs per eligible enrolled AIDS Waiver participant. All other AIDS Waiver services are reimbursed at cost, but not in excess of the rates established in the AIDS Waiver Program Rate Schedule.

Each AIDS Waiver agency is required by agreement to develop, implement, and maintain written fiscal policies and procedures that address:

- Tracking of services ordered, billed, and delivered;
- Tracking of costs of services for each participant to assure that the annual \$13,209 maximum allowable reimbursement for each participant is not exceeded;
- Separation of duties for accounting staff responsible for accounts payable and receivable;
- Identification of expenditures by program, program components, and/or budgetary category; and
- The preparation and availability of financial statements for case management staff (for participant services portion) and the board of directors, or county board of supervisors, on a monthly basis.

Additionally, the following financial performance indicators are reviewed during the CDPH/OA Program Compliance Reviews conducted at least every 24 months at each AIDS Waiver agency:

- Licensing and certification of providers;
- Subcontracts with providers of direct care services;
- Direct care services ordered were actually delivered and accurately billed;
- Claims were submitted and paid in a timely manner;
- Only claims for Medi-Cal eligible participants enrolled in the AIDS Waiver were paid;
- Cost avoidance and resource evaluation are being overseen by qualified case managers and documented in the participant chart;
- Vouchers/expenditures for nutritional supplements and transportation vouchers/expenditures are tracked separately by participant, date, and amount; and
- Qualified case manager staff-to-participant ratios meet CDPH/OA requirements; Full Time Equivalent (FTE) per program is documented and is accurate.

AIDS Waiver agency bi-annual Progress Reports submitted to CDPH/OA include the following financial reporting:

- Existing, new, and terminated subcontractors by name, type of service provided, licenses and/or certifications (if applicable), and effective dates of the subcontract;
- Plans for replacing terminated subcontracts/services if necessary to meet requirements; and
- Requests for technical assistance in billing, budget issues, and policy and procedure development.

CDPH/OA staff reviews paid claim data to monitor utilization of services. Reports are analyzed by CDPH/OA to determine the following:

- Lack or gaps in billing;
- Types and units of service billed; and
- Comparisons with statewide average billing per participant (total billed and by service).

AIDS Waiver Agencies are contacted by the policy or program analyst if irregularities are found. CDPH/OA reviews annual calendar year service utilization to evaluate statewide and sub-state trends.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of AIDS Waiver claims using the correct rates and codes as specified by the waiver requirements**  
**Numerator - Number of AIDS Waiver claims using the correct rates and codes / Denominator - Total number of claims submitted**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

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

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- b. **Sub-assurance:** *The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

**Performance Measures**

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

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

**Performance Measure:**  
**Number and percent of approvable reimbursements rates Numerator-**  
**approvable reimbursement rates reviewed. Denominator-Program Compliance**  
**Review sample size**

**Data Source** (Select one):  
**Financial records (including expenditures)**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 22.11% sample size
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
CDPH/OA works collaboratively with the AIDS Waiver Agency’s Project Director and case managers to immediately address findings. When CDPH/OA identifies a concern that is not an immediate danger to the participant, technical assistance is provided during the on-site review. All substantive findings are discussed with the AIDS Waiver Agency during the exit conference, and formal written Summary of Findings is provided to the AIDS Waiver Agency following the review. The AIDS Waiver Agency is required to submit a CAP which remediates all identified findings. CDPH/OA reviews CAPs and provides ongoing monitoring to ensure the AIDS Waiver Agency appropriately addresses the findings.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No**
- Yes**

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

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

AIDS Waiver Agencies bill for waiver services based on the maximum allowable rate which is defined in the Medi-Cal Provider Manual and can be found at the following link: [http://files.medi-cal.ca.gov/pubsdoco/manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp).

In 1989, at program inception, DHCS determined waiver service rates by first comparing and analyzing actual rates paid statewide in local communities. From these results, statewide maximum reimbursable rates were set for each service and a built-in cost-of-living (percentage) increase was scheduled for 1990 and 1991. For example, the monthly case management fee is determined by surveying AIDS Waiver agencies to collect information on staff salaries, number of hours spent monthly performing case management and administrative activities. To maintain cost effectiveness, a monthly and/or annual cap for some services and a maximum annual participant cap were set. Staff-to-participant ratios were also determined.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:
1. Direct care service providers submit invoices to the AIDS Waiver Agency; who review the invoices to determine if the service(s), date(s), frequency, and amount(s) billed are accurate.
  2. The AIDS Waiver Agency submits claims, which include subcontractor expenditures and Waiver agency case management fees, to DHCS' Medicaid Management Information System (MMIS) fiscal intermediary. The frequency of claim submission varies by AIDS Waiver Agency, e.g., semi-weekly, monthly, quarterly.
  3. The fiscal intermediary pays AIDS Waiver Agencies based upon the claims submitted.
  4. AIDS Waiver Agencies reimburse subcontractors within 30 days of receipt of payment from the fiscal intermediary.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

**Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

1. The fiscal intermediary performs routine and ad hoc claim reviews to assure that payment is only made when the individuals were eligible for Medicaid waiver payment.
2. The AIDS Waiver Agency qualified case manager, Project Director, and/or fiscal officer review billings to assure that services are included in the approved participant centered service plan, and to verify the accuracy of the services utilized, amount billed, and date(s) services were provided.
3. During Program Compliance Reviews, CDPH/OA staff reviews a sampling of AIDS Waiver Agency and participant records to assure adequate documentation exists to validate provider billings and that billings were accurately made. Invalid or inaccurate claim submittals are automatically denied and the provider notified through a Remittance Advice Detail (RAD). Paid claims that are not valid or accurate, based on the AIDS Waiver agency agreement with CDPH/OA or an audit finding, may be recovered by the State and/or Federal Government.
4. AIDS Waiver Agencies are required to submit a copy of their single, organization-wide, financial and compliance audit, as needed per fiscal year.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

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### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

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### I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

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### I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Approximately 1/4 of AIDS Waiver providers are local county governments. They receive the same monthly flat administration and case management reimbursement for administering the AIDS Waiver and providing case management as received by all AIDS Waiver agencies. The rate does not exceed reasonable costs incurred in furnishing this service.

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver**

services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

## Appendix I: Financial Accountability

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### I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

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### I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**Applying to Become An AIDS Waiver Agency** – Any local county government or community-based organization may apply to become an AIDS Waiver agency. To be considered, an interested party must submit a Letter of Intent to CDPH/OA indicating its interest in becoming an AIDS Waiver Agency. Through evaluative methods, CDPH/OA determines if these agencies meet requirements to become AIDS Waiver Agencies. The applicant must identify effective date and counties to be served, a statement that becoming an AIDS Waiver Agency is cost and administratively feasible, estimated monthly and annual number of participants eligible for AIDS Waiver, and the steps to be taken to assure maintenance of estimated AIDS Waiver caseload.

**Provider Number** – Each agency must obtain a National Provider Identifier (NPI) before applying to become an AIDS Waiver provider. Agencies must complete the AIDS Medi-Cal Waiver Program Medi-Cal Provider Application portion of form CDPH 8545. The completed form must then be submitted to the DHCS Provider Enrollment Branch, Payment Systems Division for processing. If approved, the DHCS Provider Enrollment Branch issues the AIDS Waiver provider number.

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

**Provider Qualifications /Requirements** - The agreement model between CDPH/OA and AIDS Waiver Agencies contains provider qualifications and all other applicable requirements.

**Payment** - DHCS's fiscal intermediary pays AIDS Waiver agencies monthly administration and case management fees, per eligible enrolled AIDS Waiver participants. All other AIDS Waiver services are reimbursed at cost, but not in excess of the rates published in the AIDS Waiver Program Billing Codes and Rates section of Part 2 of the Medi-Cal Inpatient/Outpatient Manual. Direct care service providers invoice the AIDS Waiver Agency for services rendered. The AIDS Waiver Agency submits claims to the State's MMIS fiscal intermediary. The Waiver agency reimburses the subcontractor within 30 days of receipt of payment from the fiscal intermediary.

**Informing New Enrollees** – Once an individual is determined eligible to enroll in the AIDS Waiver, a qualified case manager describes the AIDS Waiver services, limitations, requirements, and any feasible alternative programs to him/her, including the option of being institutionalized as compared to receiving home and community-based services through the AIDS Waiver. The qualified case manager answers any questions the interested individual/applicant may have.

The qualified case manager then presents and explains the Informed Consent/Agreement to Participate and AIDS Waiver Notice of Action: Your Right to State Fair Hearing standard forms to the applicant. Prior to enrollment/development of the Participant Centered Service Plan, the qualified case manager answers any questions the applicant/interested individual may have.

**Enrollment and Selections** – In order to participate in the AIDS Waiver, an applicant must sign the Informed Consent/Agreement to Participate form, initialing and dating the acknowledgment of rights and responsibilities, grievance procedures, and the Notice of Action. The applicant must also choose between receiving services under the AIDS Waiver or other care/institutionalization at the time of enrollment. The applicant is then provided the opportunity to choose his/her direct care providers.

**Licensing and Certification (L&C) Standards** – AIDS Waiver Agencies are required to establish and implement policies and procedures to assure that their staff, providers, and provider staff meet licensing and/or certification standards and adhere to other state requirements. Some providers are required to be licensed and others only require certification. Specifically:

- L&C is required for all AIDS Waiver Agencies that provide hands-on care;
- L&C is not required for trained individuals providing homemaker services as they do not provide hands-on care. Subcontracted providers conduct a basic orientation on HIV/AIDS, infection care and confidentiality to trained individuals providing homemaker services;
- AIDS Waiver Agencies oversee licensed and non-licensed/non-certified providers to assure adherence to state and federal regulations regarding monitoring visits by RNs; and

- Exemptions require prior written approval from CDPH/OA. Exemptions may consist of the following staff qualifications when appropriate credentialed staff is not available for hire in the local area. Appropriate supervision is provided by individuals meeting the credential requirement. AIDS Waiver agency Requirements – AIDS Waiver Agencies are required to:
  - Have a system in place to verify provider and provider staff qualifications, training and licensure prior to any service being provided to participants and periodically thereafter; and
  - Use model subcontract language to assure these requirements are met for providers and provider staff.

Monitoring of AIDS Waiver agency Subcontractors - CDPH/OA requires AIDS Waiver Agencies to have systems in place for monitoring subcontractor staff orientation, training and licensure (i.e., current licensure, appropriate contract language/requirements, appropriate rates). This is a required element of the agreement between CDPH/OA and AIDS Waiver Agencies that guarantees compliance prior to services being provided.

**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

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

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

## Appendix I: Financial Accountability

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

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

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

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

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

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

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Each AIDS Waiver service has a unique billing code. Residential facility room and board is not a billable AIDS Waiver service.

**Appendix I: Financial Accountability****I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)****a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- Nominal deductible
- Coinsurance

- Co-Payment  
 Other charge

Specify:

### Appendix I: Financial Accountability

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#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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### Appendix I: Financial Accountability

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#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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### Appendix I: Financial Accountability

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#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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### Appendix I: Financial Accountability

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#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Hospital, Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	5536.08	21284.00	26820.08	99400.00	29178.00	128578.00	101757.92
2	4483.30	21284.00	25767.30	104370.00	30053.34	134423.34	108656.04
3	4482.04	21284.00	25766.04	109588.50	30954.94	140543.44	114777.40
4	4484.51	21284.00	25768.51	115067.93	31883.59	146951.52	121183.01
5	4484.27	21284.00	25768.27	120821.32	32840.10	153661.42	127893.15

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	1551	419	1132
Year 2	1443	390	1053
Year 3	1342	362	979
Year 4	1248	337	911
Year 5	1160	313	847

## Appendix J: Cost Neutrality Demonstration

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

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The Average Length of Stay (ALOS) is based on Calendar Year (CY) 2014 Medi-Cal paid claims data and the CY 2014 Waiver enrollment file. The utilization rate for services is 82% (301 ALOS/365 Days).

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

**Estimated Number of Users:** The percentage of the number of users of the service from the 2014 Medi-Cal paid claims data applied to the unduplicated number of participants in Appendix B-3. The number of unduplicated participants for each waiver year of this renewal is calculated using an average annual rate of change in users from 2011 – 2016, resulting in a decrease of 7% per waiver year. The estimate of unduplicated participants in Waiver Year One is based on the most recent year of complete data available, 1668 participants in calendar year 2015. A 7% decrease is applied for Waiver Years 1-5.

**Units/User:** The total unit count from the 2014 Medi-Cal paid claims report divided by the number of users from the 2014 Medi-Cal paid claims report multiplied by the ALOS factor ( $301/365=82\%$ ).

**Cost/Unit:** Actual Medi-Cal approved reimbursement rate for each service category.

**Total Cost:** Estimated Number of Users multiplied by the Units/User multiplied by the Cost/Unit.

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

Factor D' is based on the actual cost of health care furnished, in addition to waiver services, during CY 2014. The number of users for each year of this renewal is applied.

Factor D' does not include:

1. Cost of institutional care for participants who did not return to the waiver after institutionalization during CY 2014;
2. Costs of institutional care incurred before the individual was admitted into the waiver during CY 2014; and
3. Costs of prescribed drugs furnished to Medicare/Medi-Cal dual eligibles during CY 2014.

The costs were compiled from the 2014 Medi-Cal paid claims reports, to report utilization and expenditures of waiver services and State Plan expenditures of participants enrolled during CY 2014. The Medi-Cal paid claims report included the above exclusion criteria. This calculation is performed for each level of care (Acute/NF) and the weighted average is completed in Appendix J-1.

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

Factor G is based on the actual CY 2014 institutional costs for non-waiver State Plan beneficiaries with an AIDS diagnosis code, HIV/AIDS specific laboratory testing CPT-4 codes, or HIV/AIDS specific drug codes. The total institutional costs are divided by the total number of unduplicated individuals who have been institutionalized in an Acute or NF level for at least 180 days in CY 2014. Institutional costs for each year of this waiver renewal are calculated using an average growth rate of five percent applied to the 2014 institutional costs. The average annual growth rate was derived from the net change in data included in initial expenditure reports for CYs 2008 and 2009.

This calculation is performed for each level of care (NF/Acute) and the weighted average is completed in Appendix J-1.

The target-group specific data used to establish the Factor G value is as follows:

	2014 Institutional Costs (# persons)	2014 Ancillary Costs (# persons)
Hospital Inpatient	\$ 5,550,243 (13)	\$1,163,160(13)
Nursing Facility	\$26,854,287 (313)	\$8,290,432 (311)

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

Factor G' is based on the actual cost of health care furnished, in addition to the institutional costs in Factor G, for CY 2014. Factor G' does not include:

1. Costs of prescribed drugs furnished to Medicare/Medi-Cal dual eligibles during CY 2014.

The costs were compiled from the 2014 Medi-Cal paid claims reports, to report utilization and expenditures of waiver services and State Plan expenditures of participants enrolled during CY 2014. The Medi-Cal paid claims report included the above exclusion criteria.

Health care costs other than institutional costs for each year of this waiver renewal calculated using an average growth rate of three percent applied to the 2014 health care costs. The average annual growth rate was derived from the net change in data included in initial expenditure reports for 2008 and 2009.

This calculation is performed for each level of care (NF/Acute) and the weighted average is completed in Appendix J-1.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Enhanced Case Management	
Homemaker	
Attendant Care	
Home-Delivered Meals / Nutritional Supplements	
Medi-Cal Supplements for Infants and Children in Foster Care	
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	
Non-Emergency Medical Transportation	
Nutritional Counseling	
Psychotherapy	
Skilled Nursing, Licensed Vocational Nurse	
Skilled Nursing, Registered Nurse	

## Appendix J: Cost Neutrality Demonstration

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

**d. Estimate of Factor D.**

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

**Waiver Year: Year 1**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
GRAND TOTAL:						8586463.94
Total Estimated Unduplicated Participants:						1551
Factor D (Divide total by number of participants):						5536.08
Average Length of Stay on the Waiver:						301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Enhanced Case Management Total:</b>						3372725.15
Enhanced Case Management	Month	1546	9.68	225.37	3372725.15	
<b>Homemaker Total:</b>						1245663.54
Homemaker	15 Minutes	274	1551.61	2.93	1245663.54	
<b>Attendant Care Total:</b>						1539275.64
Attendant Care	15 Minutes	319	1157.15	4.17	1539275.64	
<b>Home-Delivered Meals / Nutritional Supplements Total:</b>						2008500.00
Home-Delivered Meals / Nutritional Supplements	Month	650	20.60	150.00	2008500.00	
<b>Medi-Cal Supplements for Infants and Children in Foster Care Total:</b>						5070.00
Medi-Cal Supplements for Infants and Children in Foster Care	Month	3	5.00	338.00	5070.00	
<b>Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies Total:</b>						8503.56
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	Year	52	1.58	103.50	8503.56	
<b>Non-Emergency Medical Transportation Total:</b>						33258.23
Non-Emergency Medical Transportation	Month	166	7.02	28.54	33258.23	
<b>Nutritional Counseling Total:</b>						2376.19
Nutritional Counseling	Hour	28	2.56	33.15	2376.19	
<b>Psychotherapy Total:</b>						329060.97
Psychotherapy	Hour	245	27.90	48.14	329060.97	
<b>Skilled Nursing, Licensed Vocational Nurse Total:</b>						509.67
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	8	9.18	6.94	509.67	
<b>Skilled Nursing, Registered Nurse Total:</b>						41520.97
Skilled Nursing, Registered Nurse	15 Minutes	43	96.08	10.05	41520.97	
<b>GRAND TOTAL:</b>						8586463.94
Total Estimated Unduplicated Participants:						1551
Factor D (Divide total by number of participants):						5536.08
Average Length of Stay on the Waiver:						301

## Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (6 of 9)****d. Estimate of Factor D.**

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

**Waiver Year: Year 2**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Enhanced Case Management Total:</b>						3137114.34
Enhanced Case Management	Month	1438	9.68	225.37	3137114.34	
<b>Homemaker Total:</b>						1159285.41
Homemaker	15 Minutes	255	1551.61	2.93	1159285.41	
<b>Attendant Care Total:</b>						1433118.70
Attendant Care	15 Minutes	297	1157.15	4.17	1433118.70	
<b>Home-Delivered Meals / Nutritional Supplements Total:</b>						348340.85
Home-Delivered Meals / Nutritional Supplements	Month	605	20.60	27.95	348340.85	
<b>Medi-Cal Supplements for Infants and Children in Foster Care Total:</b>						5070.00
Medi-Cal Supplements for Infants and Children in Foster Care	Month	3	5.00	338.00	5070.00	
<b>Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies Total:</b>						7849.44
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	Year	48	1.58	103.50	7849.44	
<b>Non-Emergency Medical Transportation Total:</b>						31054.37
Non-Emergency Medical Transportation	Month	155	7.02	28.54	31054.37	
<b>Nutritional Counseling Total:</b>						2206.46
Nutritional Counseling	Hour	26	2.56	33.15	2206.46	
<b>Psychotherapy Total:</b>						306228.17
Psychotherapy	Hour	228	27.90	48.14	306228.17	
<b>GRAND TOTAL:</b>						6469401.59
Total Estimated Unduplicated Participants:						1443
Factor D (Divide total by number of participants):						4483.30
Average Length of Stay on the Waiver:						301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Skilled Nursing, Licensed Vocational Nurse Total:</b>						509.67
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	8	9.18	6.94	509.67	
<b>Skilled Nursing, Registered Nurse Total:</b>						38624.16
Skilled Nursing, Registered Nurse	15 Minutes	40	96.08	10.05	38624.16	
<b>GRAND TOTAL:</b>						6469401.59
Total Estimated Unduplicated Participants:						1443
Factor D (Divide total by number of participants):						4483.30
Average Length of Stay on the Waiver:						301

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

#### Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Enhanced Case Management Total:</b>						2918956.18
Enhanced Case Management	Month	1338	9.68	225.37	2918956.18	
<b>Homemaker Total:</b>						1077453.50
Homemaker	15 Minutes	237	1551.61	2.93	1077453.50	
<b>Attendant Care Total:</b>						1331787.08
Attendant Care	15 Minutes	276	1157.15	4.17	1331787.08	
<b>Home-Delivered Meals / Nutritional Supplements Total:</b>						324158.51
Home-Delivered Meals / Nutritional Supplements	Month	563	20.60	27.95	324158.51	
<b>Medi-Cal Supplements for Infants and Children in Foster Care Total:</b>						3380.00
Medi-Cal Supplements for Infants and Children in Foster Care	Month	2	5.00	338.00	3380.00	
<b>Minor Physical Adaptations to the Home / Specialized</b>						7358.85
<b>GRAND TOTAL:</b>						6014893.15
Total Estimated Unduplicated Participants:						1342
Factor D (Divide total by number of participants):						4482.04
Average Length of Stay on the Waiver:						301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Medical Equipment and Supplies Total:</b>						
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	Year	45	1.58	103.50	7358.85	
<b>Non-Emergency Medical Transportation Total:</b>						28850.52
Non-Emergency Medical Transportation	Month	144	7.02	28.54	28850.52	
<b>Nutritional Counseling Total:</b>						2036.74
Nutritional Counseling	Hour	24	2.56	33.15	2036.74	
<b>Psychotherapy Total:</b>						284738.47
Psychotherapy	Hour	212	27.90	48.14	284738.47	
<b>Skilled Nursing, Licensed Vocational Nurse Total:</b>						445.96
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	7	9.18	6.94	445.96	
<b>Skilled Nursing, Registered Nurse Total:</b>						35727.35
Skilled Nursing, Registered Nurse	15 Minutes	37	96.08	10.05	35727.35	
<b>GRAND TOTAL:</b>					6014893.15	
Total Estimated Unduplicated Participants:					1342	
Factor D (Divide total by number of participants):					4482.04	
Average Length of Stay on the Waiver:						301

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

#### Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Enhanced Case Management Total:</b>						2713887.51
Enhanced Case Management	Month	1244	9.68	225.37	2713887.51	
<b>Homemaker Total:</b>						1004714.02
Homemaker					1004714.02	
<b>GRAND TOTAL:</b>					5596665.98	
Total Estimated Unduplicated Participants:					1248	
Factor D (Divide total by number of participants):					4484.51	
Average Length of Stay on the Waiver:						301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minutes	221	1551.61	2.93		
<b>Attendant Care Total:</b>						<b>1240106.08</b>
Attendant Care	15 Minutes	257	1157.15	4.17	1240106.08	
<b>Home-Delivered Meals / Nutritional Supplements Total:</b>						<b>301127.71</b>
Home-Delivered Meals / Nutritional Supplements	Month	523	20.60	27.95	301127.71	
<b>Medi-Cal Supplements for Infants and Children in Foster Care Total:</b>						<b>3380.00</b>
Medi-Cal Supplements for Infants and Children in Foster Care	Month	2	5.00	338.00	3380.00	
<b>Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies Total:</b>						<b>6868.26</b>
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	Year	42	1.58	103.50	6868.26	
<b>Non-Emergency Medical Transportation Total:</b>						<b>26847.01</b>
Non-Emergency Medical Transportation	Month	134	7.02	28.54	26847.01	
<b>Nutritional Counseling Total:</b>						<b>1867.01</b>
Nutritional Counseling	Hour	22	2.56	33.15	1867.01	
<b>Psychotherapy Total:</b>						<b>264591.88</b>
Psychotherapy	Hour	197	27.90	48.14	264591.88	
<b>Skilled Nursing, Licensed Vocational Nurse Total:</b>						<b>445.96</b>
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	7	9.18	6.94	445.96	
<b>Skilled Nursing, Registered Nurse Total:</b>						<b>32830.54</b>
Skilled Nursing, Registered Nurse	15 Minutes	34	96.08	10.05	32830.54	
<b>GRAND TOTAL:</b>						<b>5596665.98</b>
Total Estimated Unduplicated Participants:						1248
Factor D (Divide total by number of participants):						4484.51
Average Length of Stay on the Waiver:						301

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and

Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Enhanced Case Management Total:</b>						2521908.33
Enhanced Case Management	Month	1156	9.68	225.37	2521908.33	
<b>Homemaker Total:</b>						931974.55
Homemaker	15 Minutes	205	1551.61	2.93	931974.55	
<b>Attendant Care Total:</b>						1153250.40
Attendant Care	15 Minutes	239	1157.15	4.17	1153250.40	
<b>Home-Delivered Meals / Nutritional Supplements Total:</b>						279824.22
Home-Delivered Meals / Nutritional Supplements	Month	486	20.60	27.95	279824.22	
<b>Medi-Cal Supplements for Infants and Children in Foster Care Total:</b>						3380.00
Medi-Cal Supplements for Infants and Children in Foster Care	Month	2	5.00	338.00	3380.00	
<b>Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies Total:</b>						6377.67
Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies	Year	39	1.58	103.50	6377.67	
<b>Non-Emergency Medical Transportation Total:</b>						24843.50
Non-Emergency Medical Transportation	Month	124	7.02	28.54	24843.50	
<b>Nutritional Counseling Total:</b>						1782.14
Nutritional Counseling	Hour	21	2.56	33.15	1782.14	
<b>Psychotherapy Total:</b>						247131.50
Psychotherapy	Hour	184	27.90	48.14	247131.50	
<b>Skilled Nursing, Licensed Vocational Nurse Total:</b>						382.26
Skilled Nursing, Licensed Vocational Nurse	15 Minutes	6	9.18	6.94	382.26	
<b>Skilled Nursing, Registered Nurse Total:</b>						30899.33
<b>GRAND TOTAL:</b>						5201753.90
Total Estimated Unduplicated Participants:						1160
Factor D (Divide total by number of participants):						4484.27
Average Length of Stay on the Waiver:						301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing, Registered Nurse	15 Minutes	32	96.08	10.05	30899.33	
<b>GRAND TOTAL:</b>						5201753.90
Total Estimated Unduplicated Participants:						1160
Factor D (Divide total by number of participants):						4484.27
Average Length of Stay on the Waiver:						301