DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

JUL 31 2013

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 13-007. SPA 13-007 was submitted to my office on May 3, 2013 to update the eligibility language related to Medi-Cal's Community First Choice Option (CFCO) to comply with Section 1915(k)(1) of the Social Security Act. Additionally, this SPA enhances the quality assurance provisions related to Medi-Cal's CFCO.

The effective date of this SPA is July 1, 2013. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 3.1-k, pages 1, 1a, 5, 8, 9, 13, 14, 17, 21 & 22

If you have any questions, please contact Tom Schenck by phone at (415) 744-3589 or by email at tom.schenck@cms.hhs.gov.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Kathyryn Waje, California Department of Health Care Services
Betsi Howard, California Department of Health Care Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-007**

2. STATE: **CA**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
1915(k) 42 CFR part 441

7. FEDERAL BUDGET IMPACT:
a. FFY **2013** $0 ~~$3,858,506,810~~
b. FFY **2014** $0 ~~$2,802,504,600~~
tws

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
tws
Attachment 3.1-K, ~~pages 1-26~~ Pages 1, 1a, 5, 8, 9, 13, 14, 17, 21 and 22

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
tws
Attachment 3.1-K, ~~pages 1-25~~ Pages 1, 5, 8, 9, 13, 14 17, 21 and 22

10. SUBJECT OF AMENDMENT:

Community First Choice Option

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED:
MAY 03 2013

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: May 3, 2013

18. DATE APPROVED: JUL 31, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/13

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Gloria Nagle, Ph.D., MPA

22. TITLE: Associate Regional Administrator

23. REMARKS:
Pen and Ink Changes: Boxes 7, 8 and 9

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

Citation **3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)**

1915(k) __X__ (xiv) Community First Choice Option (CFCO) services, as described and limited in Attachment 3.1-K.

State Plan Under Title XIX of the Social Security Act
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Citation **3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)**

1915(k) __X__ (xiv) Community First Choice Option (CFCO) services, as described and limited in Attachment 3.1-K.

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Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

The State determines eligibility for CFCO services in the manner as prescribed in Social Security Act §1915(k)(1) and 42 CFR section 441.510. Effective on July 1, 2013, to receive CFCO, an individual must meet the following requirements:

(a) Be eligible for medical assistance under the State plan;

(b) As determined annually—
(1) Be in an eligibility group under the State plan that includes nursing facility services; or
(2) If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, the State must apply the same methodologies as would apply under the Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and,

(c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan.

(d) For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.

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ii. Service Delivery Models

_X_ Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

_X_ Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

_X_ Direct Cash
____ Vouchers
_X_ Financial Management Services in accordance with 441.545(b)(1).

Provider qualifications for the self-directed model are designed to ensure necessary safeguards have been taken to protect the health and welfare of participants, including criminal background checks (including finger printing) and an orientation designed to ensure providers are capable of safely providing required services.

Providers convicted of fraud are excluded under the federal regulations as specified in 42 CFR section 1001.101 and those convicted of elder and specified child abuse are also excluded as allowed under federal law pursuant to 42 CFR 1002.2. The recipient may hire their provider of choice regardless of any other felony convictions utilizing the statutory waiver process where applicable.

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iii. Service Package

A. The following are included CFCO services:

1. Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and health-related tasks through hands-on assistance, supervision, or cueing such as Domestic Services; Related Service; Personal Care Services; and Paramedical Services. The State will be claiming a service match for these activities.

    - The term Domestic Services means specific tasks related to household chores, such as dusting, sweeping and mopping.

    - The term Heavy Cleaning means thorough cleaning of the home to remove hazardous debris or dirt.

    - The term Related Services means specific tasks related to Domestic Services, such as meal preparation, laundry and shopping.

    - The term Personal Care Services means specific tasks related to basic personal services, such as eating, grooming, and bathing.

    - The term Paramedical Services means specific tasks related to the needs of an individual, which are directed by licensed health care professionals, to be performed by an attendant.

    - The term Protective Supervision means observing behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard or accident.

    - The term Yard Hazard Abatement means light work in the yard to include removal of high weeds, rubbish, ice and snow, and other hazardous substances which constitute a hazard.

    When assessing needs, the social worker uses the Hourly Task Guidelines (HTGs) which specify a range of time that can be authorized for each of the services. Exceptions are allowed for time authorized above or below the HTGs. These HTGs apply regardless of the service delivery option.

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The maximum hours available for the above CFCO services is 283 hours per month. The maximum amount for Restaurant Meal Allowance is $62 per month. Individuals under twenty-one (21) years of age pursuant to EPSDT may receive additional services if determined to be medically necessary.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks. The State will be claiming a service match for these activities.

   California provides the acquisition, maintenance and enhancement of skills through Teaching and Demonstration. Social workers assess and authorize this support, which provides training and demonstration of an assessed service, to a physically and mentally capable individual, in order to achieve greater independence by potentially performing the task for him or her. This support is time-limited to three months with a reasonable expectation that the individual will acquire the skills necessary to perform the task at the end of the three months. If the individual does not acquire such skills after three months, the services will be re-authorized as needed in the individual's person-centered plan. The Teaching and Demonstration services are performed by an IHSS provider of the recipient's choice.

3. Back-up systems or mechanisms to ensure continuity of services and supports. The State will not be claiming a service match for these activities.

   The Individualized Back-up and Risk Assessment process is a multi-faceted process that all recipients, and their social workers, complete to assess risks and determine the best back-up for each recipient during the initial and annual face-to-face visits as administrative activities of the CFC program. This process includes the following components, and is accomplished through discussion and negotiation between the parties involved (including any individuals the recipient chooses):

   - **Program Assessment** – During the program assessment, specific risks are identified based on an individual's personal care and domestic and related service needs. Once these needs are identified, the social worker reviews service options with the individuals, and authorizes services that will help the individual stay safely in their home. In addition to program specific areas, additional risk areas are discussed, such as issues around living arrangements (i.e. alone or with others, etc.), evacuation/environmental factors, and communications abilities.
   - **Referrals** – Appropriate referrals are processed to other government public assistance programs or community service agencies when social workers

identify recipients' needs that are outside the scope of the CFC program. These service referrals assist in supplementing CFC benefits to help recipients remain safely in their own homes and communities.

- **Individualized Back-Up Plan** – During the discussion, individuals in the recipient's life that may be called upon when a provider has not arrived as scheduled, or another issue arises that could potentially put the recipient at risk, are discussed and identified. These individuals' contact information (telephone, pager, etc.) are included in the Individualized Back-Up Plan, along with entities (Police, Fire Department, Adult Protective Services, etc.) and their contact numbers, plus 9-1-1, that are provided to assist the recipient, if needed.
- **Disaster Preparedness** – Finally, the recipient and social worker discuss individual health needs that are listed in the County's Disaster Preparedness Assessment Plan and utilized during a disaster by county first responders.

This Individualized Back-Up and Risk Assessment process identifies risks and mitigates these potential issues through program services, referrals to other available programs and services, identified individuals personal to the recipient, emergency contacts, and disaster preparedness and is agreed upon by the recipient and social worker completing this process.

4. Voluntary training on how to select, manage, and dismiss attendants. The State will not be claiming a service match for this activity.

   Voluntary training on how to select, manage, and dismiss attendants will be made available to participants by social workers during initial assessment and all reassessments as an administrative activity of the CFC program. The training will be provided in various formats, i.e., Consumer Handbooks and Fact Sheets developed by the California Department of Social Services (CDSS). The training materials will be provided to participants by their social worker, who will also explain the materials and answer participants' questions, including how to request a particular service.

B. The State elects to include the following CFCO permissible service(s):

1. _X_ Expenditures relating to a need identified in an individual's person-centered plan of services that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

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- This permissible service will be limited to those participants choosing the Restaurant Meal Allowance (RMA). Permissible Purchases are allowed for the purchase of prepared meal services for individuals with an assessed need for meal preparation, meal clean-up and shopping for food. Permissible purchases are in lieu of meal preparation, meal clean-up and shopping for food. See section xii. Permissible Purchases for details.

2. ____Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a community-based home setting where the individual resides.

C. County social workers will perform the following Support System Service activities:
- appropriately assess an individual's service needs before enrollment;
- provide appropriate information, training and assistance to ensure an individual is able to manage the services and budgets;
- communicate information to the individual in a manner and language that is understandable by the individual;
- provide person-centered planning;
- provide a process for changing the person-centered service plan/budget
- provide information on the grievance process;
- review the risks and responsibilities of self-direction;
- have the ability to choose freely from available home and community-based attendant providers;
- identify and access services, supports, and resources;
- develop a risk management agreement and a personalized back-up plan;
- recognize and report critical incidents; and
- make information available on advocates or advocacy systems.

i. Use of Direct Cash Payments

A. _X_ The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

Only for participants receiving the following options:
- Restaurant Meal Allowance (please see Permissible Purchases, section xii.); and

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- Eligible participants who have chosen Direct Cash.
  - California will limit the receipt of Advance Pay (Direct Cash) to participants with a total assessed need of 20 hours or more per week of service in one or more of the following areas:
    (A) Any assistance with ADLs and IADLs that is considered a personal care service.
    (B) Preparation of meals.
    (C) Meal cleanup when preparation of meals and consumption of food (feeding) are required.
    (D) Paramedical services.

B. ___ The State elects not to disburse cash prospectively to CFCO participants.

v. Voluntary Disenrollment

The State will provide the following safeguards to ensure continuity of services and assure participant health and welfare during the period of transition between CFCO and traditional service delivery models.

There will be no break in service for those voluntary disenrolling and transitioning to State Plan Personal Care Services, thus assuring participant health and welfare.

Participants or their authorized/legal representative(s) may initiate disenrollment at any time by contacting the county social services office. If a voluntary disenrollment is received by mail, or is initiated by the participant's authorized/legal representative, the county will contact the participant to ensure the disenrollment request represents the wishes of the participant. The Case Management Information and Payrolling System (CMIPS) updates eligibility status changes immediately upon data entry.

vi. Assurances

(A) The State assures that any individual meeting the eligibility criteria for CFCO will receive CFC services.

(B) The state assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFCO services.

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(C) The State assures the provision of consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

(D) With respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

(E) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports – see section viii. Quality Assurance for details.

(F) The State assures the collection and reporting of information, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(G) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

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(H) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws.

(I) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

i. Service Plan

The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing:

(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is fully disclosed in writing and agreed to by the participant, or as appropriate, their representative;

Assessments of need are conducted by county social workers every 12 months or as needed when the individual's support needs or circumstances change, or at the request of the individual or the individual's representative.

County social workers facilitate and monitor the person-centered plan during initial assessments and annual reassessments, or as needed when the individual's support needs or circumstances change, or at the request of the individual or the individual's representative.

(ii) CFCO Services will be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities. CFCO services are available and provided to individuals residing in settings that meet the federal regulatory requirements for a home and community-based setting and include, but are not limited to, single-family homes, duplexes, apartments, congregate independent living communities, and settings which provide room and board.

(iii) under an agency-provider model or other model; and

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(iv) the furnishing of which:

(I) is provided by a provider who is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

(III) is provided by an individual who is qualified to provide such services, including family members.

viii. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below. It includes components for the 58 counties and for the California Department of Social Services (CDSS) in consultation with the Department of Health Care Services (DHCS). Both components must address:

i. Activities of discovery, remediation, and quality improvement, to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

The following describes the system-wide quality assurance and improvement plan CDSS, in conjunction with the 58 counties, has that includes the activities of discovery, remediation and quality improvement. This plan will help to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement to ensure the health and welfare of our CFCO participants.

County

Each of the 58 counties must create and submit to CDSS county-specific IHSS QA policies, and procedures which are in compliance with federal, State and county policies. County Policy and Procedures (P&P) must specify the processes for addressing discovery, remediation, and overall system improvement. The procedures must provide for reporting findings to program staff and supervisors for remediation, and must include detailed procedures for discovery, remediation, and tracking of critical incidents. The procedures outlined in the P&P are designed to assure the timeliness and effectiveness of the county's actions to protect participant health and welfare, and program integrity. Counties must also prepare and submit an annual Quality Assurance/Quality Improvement (QA/QI) plan that consists of an IHSS QA budget justification, an attestation from the program manager that county P&P is current, and a description of any aspect of IHSS QA that has changed from the previous year or differs from established P&P.

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Discovery

The focus of discovery is on monitoring activities and analysis. The goal is to ensure the appropriateness and quality of the services and supports provided to recipients.

Discovery is achieved through county QA activities, which include:

- Routine case file reviews;
- Home visits;
- Data review and analysis from multiple sources;
- Targeted case reviews;
- Verification of receipt of supportive services to detect and prevent fraud.

Routine case file reviews conducted by county QA staff are the primary monitoring component and a source of data collection. Counties are required to review a percentage of cases based on the number of full-time equivalent staff allocated for QA activities. The case reviews are designed to confirm that participant needs are correctly assessed and that case files contain required documentation which is appropriately completed. Case errors, omissions, and issues with service authorizations are flagged and forwarded for remediation (see "*Remediation*" section). Moreover, critical incident information discovered during a case file review is analyzed to ensure that proper resolution took place and that the relevant information was reported to the appropriate entity. Critical incidents are reported on the Quarterly Report form, SOC 824 to CDSS QA Bureau.

Home visits conducted by county staff are used to validate case file information, affirm assessments and ensure that authorized services are consistent with the participant's needs. It is the combination of these efforts that allows a participant to remain safely and independently at home. The expected outcomes of this process include statewide uniformity of services and a program of high quality and integrity.

County staff also use home visits to confirm the participant is residing in a setting that meets the home and community-based setting characteristics.

Counties are required to develop a standardized questionnaire for all QA home visits. It is designed to elicit each participant's personal preferences and experiences with the IHSS programs. The core QA components must include:

- Verification of the participant's identity;
- Discussion with the participant about his or her health issues/functional limitations;

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- Inquiry on changes in the participant's condition or functional abilities;
- Verification of the participant's understanding of authorized services and hours;
- Written notation as to whether the participant's specific circumstances impact the assessment;
- Discussion with the participant on whether the authorized supportive services meet the participant's needs;
- Observation and inquiry as to the quality of supportive services rendered by the provider;
- Confirmation that the participant understands the Emergency Back-Up Form and how to use the information;
- Discussion with the participant on the availability of alternative resources;
- Inquiry on the participant's understanding of potential abuse, neglect and exploitation or need for adult or child protective services;
- Confirmation that all individual participant service needs identified are addressed in the service plan;
- Confirmation that the participant understands the right to request a State Hearing including the provision for continuation of disputed services until a State Hearing decision is rendered in response to the participant request for a State Hearing, if appropriate; and
- Assessment of participant satisfaction with services received and their provider(s).

Data review and analysis is conducted on data from a variety of sources including:

- Appeals data;
- Public Authorities;
- Quarterly Reports;
- CMIPS ad hoc reports;
- CMIPS monthly reports; and
- Consumer satisfaction surveys.

Counties report to CDSS quarterly, but the primary goal of the ongoing review and analysis is to identify areas requiring remediation and make provisions for continuous system improvement.

Targeted case reviews are required annually from all counties, and may be selected based on indications from any other stage of discovery. The goal of targeted reviews is to provide

opportunity for more detailed analysis in areas that appear to be outside the expected norms, and provide for remediation as appropriate. Common targeted review areas currently in use include:

- Providers who claim working in excess of 300+ hours in a month
- Review of Protective Supervision cases
- Review of children's cases
- Hospital stay error rate study
- Provider is also recipient
- Review of denied applications
- 60 days without timesheet activity
- Paychecks mailed out of state

Verification of receipt of services is accomplished through several means. QA home visits provide primary insight into the level and quality of services being provided, while unannounced home visits by trained county staff are conducted specifically to verify "the receipt of services, the quality of services, and consumer wellbeing." Recipient signatures on all timesheets serve as tertiary means of verifying receipt of services. Issues around insufficient or sub-par services must be documented and sent for priority remediation.

Remediation

The information collected during the discovery process may reveal a specific problem and/or a program weakness. County QA staff must act to correct the problem, identify the weakness and address the cause to prevent recurrence. The county QA staff must:

- Take action to resolve the issue;
- Ensure each issue discovered is resolved;
- Document the resolution and action taken in the case file; and
- Provide training to county social service staff specific to the issue discovered.

System Improvement

County QA staff are required to take action to resolve issues that are systemic in nature. Staff identify opportunities for systemic improvement by analyzing program data. The findings provide insight for determining whether issues are program deficiencies/county-wide trends. Staff seek effective remediation measures and develop continuous improvement processes.

Corrective actions designed to eliminate systemic problems may include written program directives, modified procedures, and/or targeted case reviews. In all cases involving a systemic issue, county QA staff perform follow-up activities including training and technical assistance. QA staff document that remedial actions have been taken according to their county protocols.

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Each county submits a completed Quarterly Report form (SOC 824) by e-mail to the CDSS QA Bureau covering the QA/QI activities conducted during the reporting quarter. The report includes the number of, and information gathered from, routine scheduled reviews, home visits, and targeted reviews. It also includes critical events/incidents identified, actions taken on critical events/incidents, and any system improvement efforts made as a result of issues identified during the quarter.

CDSS

The CDSS has two roles in the QA/QI Plan, as reviewer of county QA/QI plans and activities, and as conductor of its own QA/QI activities. These two functions are separate but often overlap, and together provide an additional layer of validation of quality assurance and program integrity.

CDSS Review of Counties QA/QI

The CDSS QA staff monitoring is accomplished by: reviewing county P&P, annual QA/QI Plans, and Quality Improvement Action Plans (QIAPs); reviewing, analyzing, aggregating and reporting on county Quarterly Reports; performing case reviews, including county QA reviewed files and denied applications; and observing county QA home visits.

Based on the findings from these reviews, CDSS helps counties by:

- Collaborating on the creation of county action plans;
- Collaborating on the development of new county P&P;
- Providing technical assistance in the development of annual QA/QI plans; and
- Providing training on specific issues to individual counties as well as statewide.

The goal of the CDSS review of county QA/QI activities is to ensure that initial assessments and reassessments are conducted in a timely and uniform manner, participant needs are correctly assessed, and the health, welfare, and quality of life of participants is maintained.

Discovery

As part of its discovery activities, CDSS carries out regularly scheduled county visits, during which the QA staff perform case file reviews and observe county QA staff conducting home visits. The CDSS QA monitoring staff conducts monitoring of the State's 58 counties annually.

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Prior to a site visit, CDSS QA reviews the county's P&P and annual QA/QI Plan, and pulls data to analyze the county as compared to other counties. County performance is reviewed in the areas of:

- Timely reassessment compliance rate;
- Proportion of severely impaired recipients to total caseload;
- Average hours assessed per case;
- Average cost per case;
- IHSS staff participation in State-sponsored training; and
- Participation in recent data match and error rate study activities

At the county office, CDSS QA staff begin with an introduction, discussion of the county's P&P and annual QA/QI Plan, the comparison data (as described above), and an opportunity for county to discuss any issues that may impact the visit or the result of the review. The CDSS QA staff then review:

- A predetermined sample of case files for correct application of federal and State regulations and requirements, proper use of required documents, appropriate and well documented justification for services, appropriate and clearly documented reasons for exceptions to hourly task guidelines, and evidence that individualized risk planning has occurred;
- A sample of case files reviewed by county QA staff is evaluated for QA activities, the appropriateness of the forms, and any corrective actions taken;
- Appropriateness of denied and disenrolled cases to ensure that denial of likely cases and involuntary disenrollments from the program were appropriate;
- County policies and procedures for service registries and training available to providers and participants;
- Intake and enrollment procedures, including the participants' assessment/annual reassessment and level of assistance;
- Provider enrollment forms and qualifications; and
- Procedures for identification, remediation, and prevention of abuse.

During the county office segment of the site visit, CDSS QA staff review the case narratives to identify possible issues. These issues include provider problems, timesheet issues or questions related to the participant's assessment/reassessment needs. CDSS QA staff evaluate the issues

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raised and the county responses. The reviewer can immediately bring the issues to the attention of county QA staff. Alternatively, CDSS staff may make comments and/or recommendations to the county at the conclusion of the county review. These comments/recommendations are given to the county QA staff to ensure follow up with the participant's social worker.

For the home visits, CDSS QA staff accompanies county QA staff. The visits are planned to allow observation of a sample designed to validate case file information and to ensure participant needs have been assessed correctly.

During a home visit, CDSS QA staff:

- Observe county QA staff during the participant interview conducted to determine consumer satisfaction with program services;
- Review services provided are appropriate to the specific needs of the participant;
- Review coordination of the participant's services;
- Review procedures for ensuring the participant has been provided information regarding available community resources;
- Survey participants regarding quality of care issues;
- Observe the participant's living arrangements, with consideration for the participant's safety in the home;
- Review the individual emergency back-up plan with the participant; and
- Review policies and procedures for addressing reportable events, incidents, complaints, and fair hearings.

The State's annual monitoring visit concludes with a face-to-face discussion among State and county QA staff. The topics covered are best practices, how state requirements were met, and positive findings and/or needed improvements. CDSS QA staff provide any necessary technical assistance at the time of the meeting or at a future date.

A site visit is followed up with a letter from CDSS QA to the director of the county department responsible for administering the supportive services program. The letter details the identified strengths and areas requiring improvement, allowing the county to take appropriate action in remediation.

The CDSS conducts data reviews in consultation with DHCS. Data review activities may include, but are not limited to analysis of:

- CMIPS Online Reports including CMIPS ad hoc reporting for targeted data collection and review;

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- Error rate studies (verification of provider payments using CMIPS and MIS/DSS or data provided by the California Department of Health Care Services (DHCS);
- Payments for deceased recipients;
- Out-of-state (provider or participant or either/both) payments;
- Inpatient hospital stay over 5 days;
- Death match review using Vital Statistics/Social Security Administration (SSA) data; and
- Consumer surveys.

Remediation

The complete array of information collected during the discovery process forms the basis for the remediation actions that are taken by CDSS QA staff. Staff use this information to evaluate, improve and refine the quality of the program provided to participants.

The issues discovered during a county visit are addressed by CDSS QA staff during the exit interview with county QA staff. The county is advised that CDSS QA staff are available to work with the county QA staff to remediate the issue(s), as well as to provide technical assistance with developing the annual QA plan, which along with all county-visit documents are included in the county annual visit file.

Upon return to the State office, CDSS QA staff compose a findings letter that documents the site visit findings and the exit interview. Feedback is also provided in the form of a monitoring summary. Both the findings letter and the monitoring summary may contain positive feedback and negative issues. The material is sent to the county welfare director. Copies are sent to the county QA staff, the IHSS program manager and other appropriate staff, and DHCS.

In preparation for subsequent county monitoring visits, CDSS QA staff review any existing monitoring documentation and corrective action plans to ensure the county has initiated the required quality improvement measures in the areas identified during previous visits.

System Improvement

Data analysis is used to determine whether an issue identified during discovery is county specific or statewide. When a systemic issue or a trend is identified, actions are taken by CDSS QA staff to move toward resolution. Measures with the potential to be the most effective and that foster continuous system improvement processes are developed for the program. Based on the determination, an appropriate remediation measure is identified.

The CDSS QA staff use the face-to-face exit interview with the county as the initial opportunity to share information with county staff regarding issues that appear to be systemic. Subsequently,

the county is sent a written findings follow-up report. Some issues documented in the report may require technical assistance from CDSS QA staff and corrective action by the county. When CDSS requests a Quality Improvement Action Plan (QIAP) from a county, the county must include in its QIAP how and when an issue will be resolved. The QIAP is due to CDSS from the county within 30 days of receipt of the request. The QIAPs are reviewed and approved by CDSS staff. County progress toward continuous improvement is monitored via regular communication between the county and CDSS staff.

When statewide systemic issues and trends are identified, CDSS QA staff initiate an all-county distribution of an All-County Information Notice (ACIN) or an All-County Letter (ACL) that contains pertinent information regarding problem areas and states the actions needed for resolution and continuous system improvement statewide. This is accomplished through:

- Updating regulations, as needed;
- Conducting QA monitoring visits to all counties;
- Presenting at CWDA regional meetings;
- Attending monthly regional QA meetings;
- Conducting workshops at annual CWDA Conferences;
- Attending monthly Long-Term Care Operations meetings;
- Updating the program material in the IHSS Training Academy; and
- Issuing statewide policy directives that reflect systemic issues and system improvement.

The goal for each activity is to promote remediation and system improvement statewide.

DHCS role

Through the ongoing CDSS-DHCS partnership, DHCS will provide final level of care determinations and other technical and clinical support, and perform periodic collaborative reviews as needed. DHCS will meet and confer with CDSS QA staff on a quarterly basis to discuss and validate that county QA/QI plans are in place, and that P&P address system improvements. Additionally, DHCS will review compilations of county QA/QI activities which are submitted to CDSS on Quarterly Report Forms (SOC 824) documenting results of counties' desk reviews, home visits, case resolutions, fraud prevention/detection and over/underpayment, critical incidents, targeted reviews and quality improvement efforts. This includes DHCS review and evaluation of CDSS QA staff remediation efforts during and after county visits.

DHCS reviews error rate studies (i.e., payments to out-of-state providers, more than five day hospital stays, etc.) which estimate the extent of payment and service authorization error and potential fraud in the provision of services. The findings are used to prioritize and direct State and county fraud detection and quality improvement efforts.

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B. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

The following are the performance measures set forth for the CFCO State Plan Amendment.

CDSS Statewide Performance Measures

Performance measures are an important element of the CDSS QA/QI plan design. The measures are designed to determine the effectiveness and functionality of the program and to identify areas where attention should be focused to assure improved outcomes. When the measures are applied and the results analyzed, these performance measures provide information used in making recommendations for continuous system improvement. The following are performance measures that focus on the QA/QI plan target areas, participant health and welfare and financial accountability.

Participant Health and Welfare

Performance Measure 1: Face-to-Face Visits

Desired Outcome: A participant and his/her county social worker have a face-to-face visit at least once a year.

1a QA Function: CMIPS data is reviewed by CDSS QA staff to ensure that this visit is occurring within a 12-month, or appropriate, timeframe for participants. Counties that drop below 80 percent compliance with this requirement will be required to develop and submit a QA Improvement Plan detailing how they will improve to at least 80% compliance with timely reassessments.

Performance Measure 1a - County Face-to-Face Visit Calculation
of statewide cases with face-to-face visits completed within 12 months / # of statewide cases = % of statewide compliance

Performance Measure 2: Individualized Back-Up Plan and Risk Assessment

Desired Outcome: An Individualized Back-Up Plan and Risk Assessment is in place for each participant.

During the initial and annual face-to-face visits, a participant and his/her county social worker collaborate to determine the best plan for the participant. Together, the participant and the case worker complete or update the Individualized Back-Up Plan and Risk Assessment form (SOC

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864) to capture the action elements of the back-up plan. A copy of the completed form is retained by the participant, ideally in a readily accessible location. The county social worker places a second copy of the form in the participant's case file.

QA Function: County and CDSS QA staff review case files to confirm that an Individualized Back-Up Plan and Risk Assessment is in place and a copy of the form is present in each participant's case file. During a home visit, QA staff confirm that the participant possesses an up-to-date copy of their plan. Case files found to be out of compliance with this requirement require immediate remediation.

Performance Measure 2a - County QA Individualized Back-Up Plan and Risk Assessment Calculation
of statewide cases reviewed that include a completed Individualize Back-Up Plan and Risk Assessment / # of statewide cases reviewed = % of statewide compliance

Performance Measure 2b - CDSS QA Individualized Back-Up Plan and Risk Assessment Calculation
of statewide cases reviewed that include a completed Individualized Back-Up Plan and Risk Assessment / # of statewide cases reviewed = % of statewide compliance

Performance Measure 3: Critical Incidents
A critical incident is one in which there is an immediate threat to the health and/or safety of a participant. Critical incidents include, but are not limited to: serious injuries caused by accident, medication error/reaction; physical, emotional or financial abuse or neglect.

Desired Outcome: When a critical incident occurs, the county social service staff responds quickly and appropriately and notes the incident in the case file, including the resolution, when known.

QA Function: County and CDSS QA staff review case files for evidence of critical incidents and the resolution, as stated.

Performance Measure 3a - County QA Critical Incident Calculation
of statewide cases reviewed that include a critical incident / # of statewide cases reviewed = % of statewide cases involving critical incidents

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Performance Measure 3b - CDSS QA Critical Incident Calculation
of statewide cases reviewed that include a critical incident / # of statewide cases reviewed = % of statewide cases involving critical incidents

Performance Measure 3c - CDSS QA Resolved Critical Incident Calculation
of statewide cases reviewed with a resolved critical incident / # of statewide county cases reviewed that include a critical incident = % of statewide resolution

Outcome Measure 1: County Plans
Desired Outcome: Counties are in compliance with their annual County QA/QI Plan.

QA Function: Prior to a county monitoring visit, CDSS QA staff review the county's annual QA/QI plan, quarterly reports, and any other information available. Upon completion of the county visit, CDSS QA staff determine the extent to which the county is in compliance with their annual plan based on data gathered from the case reviews and home visits.

Outcome Measure 1 – CDSS QA County Plan Calculation
of counties in compliance with their County QA/QI Plan / # of counties that have submitted their QA/QI Plan = % of statewide compliance

Outcome Measure 2: QI Action Plans (QIAPs)

Desired Outcome: All counties with a QIAP make the indicated corrections and institute the plan as approved by CDSS.

QA Function: When CDSS determines that a county is out of compliance in the below named areas, CDSS will issue a QIAP demand. Upon receipt of a QIAP demand, the county will submit a QIAP which explains how it will come into compliance. Upon completion of the next county visit, CDSS QA monitoring staff determines whether the county instituted the QIAP as approved by CDSS. Areas which could result in a QIAP demand include:

- Failure to abide by their approved annual plan;
- Failure to maintain 80% compliance with timely reassessments;
- Failure to submit accurate reporting documents (SOC 824, data match results, error rate studies) in a timely manner;
- Failure to participate in State-sponsored training; and

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- Required remedial actions in more than 30% cases reviewed by county QA

California Measure 2 – CDSS QA Improvement Action Plan Calculation
of counties with instituted QIAPs / # of counties with QIAPs = % of county compliance

* This requirement is only in regards to counties who have a QIAP.

Satisfaction Measure 1: Customer Service Evaluation
Desired Outcome: Program participants are satisfied their in-home service and support needs are being met by the program, are able to contact the appropriate people when needed, and are able to satisfactorily self-direct their services.

QA Function: Appropriate questions are asked to participants regarding their satisfaction of the program, services and self-direction options. Upon completion of each survey, percentages will be calculated and reviewed. CDSS QA will then use this data to determine if changes in the program are needed.

The survey(s) will be comprehensive, results will be validated, and the tool will be administered by CDSS on a statewide basis. CDSS will use the results of the survey to generate a report, which will be disseminated to counties and posted on the CDSS website.

Data Collection Methods
Data collected for the performance measures (one through five) are obtained during the county and CDSS case reviews and home visits. County data are reported to CDSS in Quarterly Reports. CDSS data are collected throughout the year and included in the CDSS QA Monitoring Summary.

Sampling Approach
CDSS will work with counties to draw a random sample of a size determined by using the sample size calculator available on the Raosoft website, http://www.raosoft.com/samplesize.html. Standard parameters are assumed: Level of Confidence ranging from 90% to 97%, margin of error ranging from +/– 3% to +/– 6%. This approach will result in similar but different size samples in each county. The actual percentage of the statewide caseload that is sampled will depend on the distribution of caseloads by county. This approach will result in a sample that has an acceptable probability of being representative of the actual CFCO population.

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Frequency of Data Collection
Data collection takes place on an ongoing basis within each aspect of the program. Performance measure data will be finalized at the end of each State fiscal year and available upon request. Counties work throughout the year to meet their individual targets and goals to assure maximum review.

Roles and Responsibilities for Data Collection
County QA staff are responsible for gathering data in keeping with the criteria set forth in State and county P&P. QA staff are also responsible for maintaining this data.

Process for Tracking and Analyzing Collected Data

Roles and Responsibilities for Tracking and Analyzing Collected Data
Counties are responsible for tracking and analyzing data gathered during QA activities. Moreover, QA staff review online CMIPS data to identify program issues specific to that county. The methodology for tracking and analyzing these data can allow for ease in reporting on the SOC 824 form. County QA staff are responsible for assuring that the data are analyzed for trends and/or program shortfalls.

The CDSS QA staff are responsible for tracking and analyzing data reported quarterly by the counties and gathered during CDSS QA county monitoring visits. CDSS staff analyze online CMIPS data and data reported on the quarterly SOC 824 forms to identify program issues specific to a particular county or statewide.

i. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

During the intake and reassessment process:

1. The county social worker assesses participant's functional abilities in all activities of daily living utilizing the following process:
   - County social service staff determines the participant's level of ability and dependence upon verbal or physical assistance by another for each of the program functions.
   - This assessment process evaluates the effect of the participant's physical, cognitive and emotional impairment on functioning.
   - The county social service staff observes the participant in their own environment.

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- Staff quantify the recipient's level of functioning using the following hierarchical five-point scale:

  Rank 1: Independent: able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his/her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

  Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.

  Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

  Rank 4: Can perform a function but only with substantial human assistance.

  Rank 5: Cannot perform the function, with or without human assistance.

2. A discussion of participant's living arrangements,
   - During the face-to-face visit, in the participant's home, the county social service staff evaluates the home for any potential hazards; how the participant deals with ambulation issues, whether they use assistive devices, what their shared living arrangement is, whether there are other individuals (non-providers) to help, etc.

3. A discussion of the participant's support system,
   - During the face-to-face visit a discussion occurs with the participant regarding who they would like to have involved in their care, and whether they want a representative, a supports broker/consultant, or any other individual such as a neighbor or friend included in all discussions.

4. The social worker/case manager reviews all documents pertaining to the participants physical or mental condition to identify potential risks to participants, and

5. Designated coding of CMIPS to indicate the participants' special needs during an emergency.

   - The participants' special needs are coded in CMIPS to allow county social service staff, in the event of an emergency or natural disaster, to inform first responders which participants need to be checked on first, and their special needs, e.g. insulin.

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B. The tools or instruments used to mitigate identified risks are described below.

- **Program Uniform Assessment Tool** – The process described in A.1., above helps the social worker and participant identify and mitigate risks that may be present. If risks cannot be or are not chosen to be mitigated, risk may be assumed by the participant during this process.

- **Individualized Back-Up Plan and Risk Assessment Form (SOC 864)** – This tool is completed during the assessment process with input from the participant and their chosen representative. This tool identifies the participants' support system, addresses back-up plan to mitigate risks, and allows the participant to understand their roles and responsibilities in obtaining CFCO services.

- **Recipient/Employer Responsibility Check-List** – This tool ensures that the recipient understands their responsibilities as the employer of their service provider.

x. Qualifications of Providers of CFCO Services

The State will permit participants to hire legally liable relatives who are qualified to provide such services, as paid providers of the home and community-based attendant services and supports identified in the service plan and budget. Self-directed model with service budget - In accordance with §441.565(c) individuals may hire any person who meets the qualifications established by the individual. Criminal background checks will be conducted and the results provided to the individual to assist the individual with the hiring process.

Providers convicted of fraud are excluded under the federal regulations as specified in 42 CFR section 1001.101 and those convicted of elder and specified child abuse are also excluded as allowed under federal law pursuant to 42 CFR 1002.2. The recipient may hire their provider of choice regardless of any other felony convictions utilizing the statutory waiver process where applicable.

The Agency Model will "provide consumer controlled services and supports under which entities contract for the provision of such services and supports." Provider qualifications for the agency-provider model are designed to ensure necessary safeguards have been taken to protect the health and welfare of participants and an orientation designed to ensure providers are capable of safely providing required services. The entities providing services under the Agency Model are not licensed by the State, but have all the appropriate business licenses.

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xi. Participant's Representative

A. _X_ The State elects to permit participants to appoint a representative to direct the provision of home and community-based attendant services and supports on their behalf.

B. ___ The State elects not to permit participants to appoint a representative to direct the provision of home and community-based attendant services and supports on their behalf.

xii. Permissible Purchases

A. _X_ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

This permissible purchase will be limited to those participants choosing the Restaurant Meal Allowance (RMA).

- RMA allows the participant to use their service budget in lieu of meal preparation, meal clean-up, and shopping for food, to purchase restaurant meals.
- Individuals who do not have assessed needs for the above services would not be eligible for RMA.
- RMA is a self-directed option for participants that increases their independence and is a substitute for their dependence on human assistance.
- RMA fits within the self-directed principles and provides participants greater choice.

B. ____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

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REIMBURSEMENT FOR MEDI-CAL HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS (COMMUNITY FIRST CHOICE OPTION SERVICES)

A. GENERAL PROVISIONS

Medi-Cal Community First Choice Option (CFCO) services are the Included Services pursuant to 42 Code of Federal Regulations §441.510 in accordance with the rules and regulations of the California Department of Health Care Services and the California Department of Social Services.

B. REIMBURSEMENT RATE LIMITATIONS

(l) A county may contract with an agency of a city, county, or city and county, a local health district, a voluntary nonprofit agency, a proprietary agency, or an individual for the purpose of providing personal care services. The rate of reimbursement will be negotiated between the county and its contractor or its contractors, consistent with applicable regulations promulgated by the California Department of Social Services or the California Department of Health Care Services.

(2) The rate of reimbursement for individual providers will be negotiated between the provider union and the individual county, or the provider union and the public authorities/non-profit consortiums, as applicable.

C. PUBLICATION OF INDIVIDUAL AND CONTRACTED PROVIDER RATES

State approved county governmental, contracted, and private individual provider rates are documented in a fee schedule and that fee schedule was last updated on March 15, 2012, and effective for services provided after that date. This fee schedule is published on the California Department of Social Services website at www.cdss.ca.gov/agedblinddisabled/PG1996.htm.

D. PAYMENTS AND UNITS OF SERVICE

(1) Reimbursements for services will be made only to providers authorized by the California Department of Social Services to provide CFCO services to beneficiaries. The rates will be based upon a time-based unit of service. The time-based unit of service is per minute based on 60 minutes per hour.

(2) The methodology for determining the beneficiary's service budget is based on the assessment of needs for the beneficiary and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for such services under the state plan and is adjusted to account for the self-directed services delivery model served in the Sec. 1915 [42 U.S.C. 1396n] G) program.

In cases where the beneficiary chooses not to have the assessed CFCO service of meal preparation, meal cleanup and/or shopping for food services provided in-home, the beneficiary can choose to have their service budget reduced by the amount calculated based on hours allocated for these services and reimbursement of $15.50 per week per person or $31 per week per couple is provided for meal preparation.