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State/Territory Name: California

State Plan Amendment (SPA) #: 12-020

This file contains the following documents in the order listed:

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

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 14, 2017

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 12-020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 29, 2012. This amendment adds participant direction as an option for existing §1915(i) State Plan Home and Community-Based Services (HCBS) respite, skilled nursing, and non-medical transportation services, and establishes community-based training services and financial management services as new services in support of participant direction.

This SPA has an effective date of April 1, 2012 and a sunset date of September 30, 2016. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-i, pages 4, 12, 13, 39, 40, 62l, 62n, 62o, 62p, 62x, 62x.1, 62y, 62z, 62aa – 62cc, and 63 – 65.
- Attachment 4.19-B, page 84a

If you have any questions, please contact Adrienne Hall at 415-744-3674 or via email at Adrienne.Hall@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Joseph Billingsley, DHCS
Jalal Haddad, DHCS
Kathyryn Waje, DHCS
Wendy Ly, DHCS
Nathaniel Emery, DHCS

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: **12-020**

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
April 1, 2012

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:
Section 1915(i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
FFY 11-12 $633,000; FFY 12-13 $1,666,000; FFY 13-14 $1,330,000; FFY 14-15 $1,518,000 estimated; FFY 15-16 $1,564,000 estimated

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-i, pages 4, 12, 13, 39, 40, 62l, 62o, 62p, 62x, 62x.1, 62y, 62z, 62aa-62cc, and 63-65

Attachment 4.19B page 84a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
09-23A Attachment 3.1-i, pages 4, 12, 13, 39, 40, 63-65
11-041 Attachment 3.1-i, pages 62l, 62n, 62o, 62p, 62x, 62y

10. SUBJECT OF AMENDMENT:
Participant Self-Directed Home and Community-Based Services

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. SIGNA [redacted]

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 6/29/12

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, MS 4506
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 06/29/2012

18. DATE APPROVED: March 13, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/2012

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: **Henrietta Sam-Louie**

22. TITLE: **Associate Regional Administrator**

23. REMARKS:

Revisions to boxes 5, 7, 8, and 9 per CMS request. CA approval dated 03/07/17.

6. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually. *(Specify):*

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2011	9/30/2012	40,000
Year 2	10/1/2012	9/30/2013	42,000
Year 3	10/1/2013	9/30/2014	44,000
Year 4	10/1/2014	9/30/2015	46,000
Year 5	10/1/2015	9/30/2016	48,000

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

Financial Eligibility

1. ☑ **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

2. Medically Needy. *(Select one)*

○	The State does not provide HCBS state plan services to the medically needy.	
◉	The State provides HCBS state plan services to the medically needy *(select one):*	
	○	The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	◉	The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. Responsibility for Performing Evaluations / Reevaluations. Independent evaluations/reevaluations to determine whether applicants are eligible for HCBS are performed (*select one*):

○	Directly by the Medicaid agency

education on a year-for-year basis.

4. **Responsibility for Service Plan Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

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

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

The IPP is developed through a person-centered process of individualized needs determination with the opportunity for active participation by the individual/representative in the plan development and takes into account the individual's needs and preferences. Person-centered planning is an approach to determining, planning for, and working toward the preferred future of the individual and her or his family. Decisions regarding the individual's goals, services and supports included in the IPP are made by agreement of the planning team.

a) *the supports and information made available* –Information available for supporting recipients in the IPP process includes but is not limited to the following documents, all of which are available using the links below or through the DDS website at www.dds.ca.gov:

1. "Individual Program Plan Resource Manual" - This resource manual is designed to facilitate the adoption of the values that lead to person-centered individual program planning. It is intended for use by all those who participate in person-centered planning. It was developed with extensive input from service recipients, families, advocates and providers of service and support.

2. "Person Centered Planning" - This publication consists of excerpts taken from the Individual Program Plan Resource Manual to provide recipients and their families information regarding person-centered planning.

3. "From Conversations to Actions Using the IPP" - This booklet shares the real life stories of how recipients can set their goals and objectives and work through the IPP process to achieve them.

4. "From Process to Action: Making Person-Centered Planning Work" - This guide provides a quick look at questions that can help a planning team move the individual program plan from process to action focusing on the person and the person's dreams for a preferred future.

For those participants who receive respite, skilled nursing, non-medical transportation, and/or community-based training services identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. As required by Title 17, CCR

section 58886, when the decision to self-direct services is made, the consumer/family member is provided with information regarding their responsibilities and functions as either an employer or co-employer as well the requirement to use and assistance in identifying a Financial Management Services provider.

b) *The participant's authority to determine who is included in the process* – As noted above, the IPP planning team, at a minimum, consists of the recipient and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and an authorized regional center representative. With the consent of the recipient/parent/representative, other individuals, may receive notice of the meeting and participate.

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

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

7. **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):*

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

8. **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 §74.53. Service plans are maintained by the following *(check each that applies)*:

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	**Habilitation – Community Living Arrangement Services**
Service Definition (Scope)*:*	
Habilitation—Community Living Arrangement Services (CLAS) includes two components, based on the setting: **A) Licensed/certified settings -** CLAS provided in these settings include assistance with acquisition, retention, or improvement in skills related to living in the community. Services and supports include assistance with activities of daily living, (e.g. personal grooming and cleanliness, bed making and household chores, eating and the preparation of food), community inclusion, social and leisure skill development and the adaptive skills necessary to enable the individual to reside in a non-institutional setting. Services provided in licensed/certified settings will take into consideration the provision of the following: 1. Private or semi-private bedrooms shared by no more than two persons with personal décor. The choice of residential settings, including making decisions regarding sharing a bedroom,	

Crisis Intervention Facilities	service design. Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers	Annually

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

☐	Participant-directed	☑	Provider managed

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

Service Title: **Respite Care**

Service Definition (Scope):

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

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

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

Respite also includes the following subcomponent:

Family Support Respite – Regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home.

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

Respite care may be provided in the following locations:

- Private residence

- Adult Day Care Facility
- Child Day Care Facility
- Licensed Preschool

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

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

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

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.
☑	Medically needy *(specify limits):*
	A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual	No state licensing category. As appropriate, a business license as required by the local jurisdiction	N/A	Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross; and has the skill, training, or education necessary to perform the required services.

		circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by relatives, and; (d) the controls that are employed to ensure that payments are made only for services rendered):
		Any of the services identified in the 1915(i) section of the State Plan may be provided by a recipient's relative if the relative meets all specified provider qualifications. The selection of the relative as a provider will only be done pursuant to applicable law and the assessment and person centered planning process. Regional centers will monitor, with DHCS and DDS oversight and monitoring, service provision and payment.
	☑	**Legal Guardians.** The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services. *(Specify: (a) the types of services for which payment may be made, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by legal guardians, and; (d) the controls that are employed to ensure that payments are made only for services rendered):*
		Any of the services identified in the 1915(i) section of the State Plan may be provided by a recipient's legal guardian if the legal guardian meets all specified provider qualifications. The selection of the legal guardian as a provider will only be done pursuant to applicable law and the assessment and person centered planning process. Regional centers will monitor, with DHCS and DDS oversight and monitoring, service provision and payment.
	☐	**Other policy.** *(Specify)*:

Participant-Direction of Services

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

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

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

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the HCBS State Plan option, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

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

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

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

Participant-Directed Service	Employer Authority	Budget Authority
Respite	☑	☐
Community-Based Training Services	☑	☐
Skilled Nursing	☑	☐
Non-medical Transportation	☑	☐

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

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
◉	Financial Management is furnished as a covered service entitled "Financial Management Service" as described in this amendment.

5. ☑ **Participant–Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

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

Participants may choose to switch to non-participant directed services at any time. In some instances, there may not be agreement with the decision to terminate participant-direction of services. In these instances, the regional center would issue a notice of action and the participant would have the opportunity for a fair hearing. Regardless of the reason for termination of participant-direction, a planning team meeting is held to update the individual program plan and facilitate the transition from participant-direction to prevent a break in services.

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

○	The State does not offer opportunity for participant-employer authority.	
◉	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐ ☑	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐ ☑	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). (*Select one):*

◉	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

	registration with the State of California as appropriate for the type of modification being purchased.		

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

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

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

☐	Participant-directed	☑	Provider managed

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

Service Title: **Non-Medical Transportation**

Service Definition (Scope)*:*

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

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

A regional center may offer family members or adult consumers option to self-direct their own non-medical transportation services

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

Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):

☐	Categorically needy *(specify limits):*

☑	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	**Nutritional Consultation**
Service Definition (Scope)*:*	
Nutritional Consultation includes the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of the consumers. These services are consultative in nature and do not include specific planning and shopping for, or preparation of meals for consumers.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

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

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

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

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

	and duty statements; and service design	

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

☐	Participant-directed	☑	Provider managed

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

Service Title: **Skilled Nursing**

Service Definition (Scope)*:*

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

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

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

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.
☑	Medically needy *(specify limits):*
	Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Registered Nurse (RN)	Business and Professions Code, §§ 2725-2742 Title 22, CCR, § 51067 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Licensed Vocational Nurse (LVN)	Business and Professions Code, §§ 2859-2873.7 Title 22, CCR, § 51069 As appropriate, a	N/A	N/A

	business license as required by the local jurisdiction where the business is located.	N/A	N/A

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

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

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

☑	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*	
Service Title:	**Specialized Medical Equipment and Supplies**

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

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

☐	Participant-directed	☑	Provider managed

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

Service Title: **Community-Based Training Service**

Service Definition (Scope)*:*

Community-based training service is a participant-directed service that allows recipients the opportunity to customize day services to meet their individualized needs. As determined by the person-centered individual program planning process, the service may include opportunities and assistance to: further the development or maintenance of employment and volunteer activities; pursue post secondary education; and increase recipients' ability to lead integrated and inclusive lives.

These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. These services enable the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care.

Educational services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

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

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

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

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community-Based Training Provider	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

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

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

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

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*	
Service Title:	**Financial Management Services**
Service Definition (Scope)*:*	
Financial Management Services (FMS) are designed to serve as a fiscal intermediary that performs financial transactions (paying for goods and services and/or processing payroll for adult consumers' or their families' workers included in the IPP) on behalf of the consumer. FMS is an important safeguard because it ensures that consumers are in compliance with Federal and state tax, labor, workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents. All FMS services shall: 1. Assist the family member or adult consumer in verifying worker citizenship status. 2. Collect and process timesheets of workers. 3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance. 4. Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities. 5. Maintain all source documentation related to the authorized service(s) and expenditures. 6. Maintain a separate accounting for each participant's participant-directed funds.	
Additional needs-based criteria for receiving the service, if applicable (specify):	

Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):			
☐	Categorically needy *(specify limits):*		
☐	Medically needy (specify limits):		
Medically needy *(specify limits):*			
Specify whether the service may be provided by a *(check each that applies):*		☐	Relative
		☐	Legal Guardian
		☐	Legally Responsible Person

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

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

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

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

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

☑	Participant-directed	☐	Provider managed

2. Policies Concerning Payment for State Plan HCBS Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians. *(Select one):*

◉	The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.	
○	The State makes payment to (check each that applies):	
	☐	**Legally Responsible Individuals.** The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services. *(Specify (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) in cases where legally responsible individuals*

	☐	*are permitted to furnish personal care or similar services, the State must assure and describe its policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual); (c) how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the State's strategies for ongoing monitoring of the provision of services by legally responsible individuals; and, (e) the controls that are employed to ensure that payments are made only for services rendered):*
	☐	**Relatives.** The State makes payment to relatives under specific circumstances and only when the relative is qualified to furnish services. *(Specify: (a) the types of relatives who may be paid to furnish such services, and the services they may provide, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by relatives, and; (d) the controls that are employed to ensure that payments are made only for services rendered):*
	☐	**Legal Guardians.** The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services. *(Specify: (a) the types of services for which payment may be made, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by legal guardians, and; (d) the controls that are employed to ensure that payments are made only for services rendered):*
	☐	**Other policy.** *(Specify)*:

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Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):**See attachment 4.19-B for descriptions of the rate setting methodologies for the services identified below.**

☐	HCBS Case Management	
☐	HCBS Homemaker	
☐	HCBS Home Health Aide	
☐	HCBS Personal Care	
☐	HCBS Adult Day Health	
☐	HCBS Habilitation	
☐	HCBS Respite Care	
☑	Other Services	
	☑	HCBS Speech, Hearing and Language Services
	☑	HCBS Dental Services
	☑	HCBS Optometric/Optician Services
	☑	HCBS Prescription Lenses and Frames
	☑	HCBS Psychology Services
	☑	HCBS Chore Services
	☑	HCBS Communication Aides
	☑	HCBS Environmental Accessibility Adaptations
	☑	HCBS Non-Medical Transportation
	☑	HCBS Nutritional Consultation
	☑	HCBS Skilled Nursing
	☑	HCBS Specialized Medical Equipment and Supplies

	☑	HCBS Specialized Therapeutic Services
	☑	HCBS Transition/Set-Up Expenses
	☑	Community-Based Training Service
	☑	Financial Management Services
For individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

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REIMBURSEMENT METHODOLOGY FOR COMMUNITY-BASED TRAINING SERVICES

The maximum rate for this service is set in State statute [Welfare and Institutions Code Section 4688.21(c)(7)] at $13.47 per hour.

Effective July 1, 2016, the above rate in conjunction with increases authorized by State statute Welfare and Institutions Code Section 4691.10 and 4691.11 increased to $14.99 per hour.

REIMBURSEMENT METHODOLOGY FOR FINACIAL MANAGEMENT SERVICES

Rates for FMS are set in State regulation, Title 17, CCR, Section 58888(b) as follows:

If the FMS functions as a fiscal/employer agent, the rate is based on the number of participant-directed services used by the consumer:

- (A) A rate not to exceed a maximum of $45.00 per consumer per month for one participant-directed service; or
- (B) A rate not to exceed a maximum of $70.00 per consumer per month for two or three participant-directed services; or
- (C) A rate not to exceed a maximum of $95.00 per consumer per month for four or more participant-directed services.

If the FMS functions as a co-employer, the rate is not to exceed a maximum of $95.00 per consumer per month for one to four co-employer services.

Effective July 1, 2016, the above rates in conjunction with the increases authorized by State statute Welfare and Institutions Code Section 4691.11 increased to the following:

- (A) A rate not to exceed a maximum of $45.88 per consumer per month for one participant-directed service; or
- (B) A rate not to exceed a maximum of $71.37 per consumer per month for two or three participant-directed services; or
- (C) A rate not to exceed a maximum of $96.86 per consumer per month for four or more participant-directed services.

If the FMS functions as a co-employer, the rate is not to exceed a maximum of $96.86 per consumer per month for one to four co-employer services.

Termination Date
The reimbursement methodologies described in this section of the state plan will sunset on September 30, 2016.