TRI-COUNTIES REGIONAL CENTER
EXECUTIVE DIRECTOR REPORT
October 4, 2014

I. BUDGET UPDATE

- **Attachment #1: ARCA: Our Next Fight – The Budget! Service Providers, Regional Centers, Advocates, and families Uniting Around Funding Issues**

- **Attachment #2: CDCAN Report: Developmental Services Task Force Meets Oct 8th – Focus on Finding Ways to Strengthen Community System for People with Developmental Disabilities**

The California Senate Human Services Committee, chaired by Senator Jim Beall (D), will be holding a hearing on the Developmental Services System on October 9, 2014 in Los Angeles. The hearing is scheduled to take place from 1:30-3:30 pm in Session Room 350 at the L.A. City Hall (Board of Public Works) located at 200 North Spring Street, Los Angeles. The hearing will focus on the impact of the budget reductions on regional center Purchase of Services (POS) and Operations (OPS) budgets. Three panels will address the challenges of the budget reductions and their impact on the Developmental Services system. Association of Regional Center Agencies (ARCA) has been asked to testify and address the impact of the budget reductions on families and persons served, regional center operations, and federal funding. There will be an opportunity for public testimony **(Attachment #1)**.

The Brown Administration's "Developmental Services Task Force", chaired by California Health and Human Services Agency Secretary Diana Dooley will hold its second meeting on October 8, 2014 from 10am-4pm at the California Department of Health Care Services building at 1700 K Street, First Floor Conference Room in Sacramento. The Developmental Services Task Force was created as a result of the Governor's veto of the provision in the FY 2014-2015 Budget Bill that would have required the Department of Developmental Services (DDS) to conduct a study with stakeholders to review and recommend an update of the core staffing formula for the 21 regional centers and the rate setting methodologies for community based service and supports. The focus of the task force is to identify ways to strengthen the community based services and supports for people with developmental disabilities. Specific issues to be examined by the task force will include community rates, the impact of the new State and Federal laws and regulations, and staffing levels at regional centers. There will be an opportunity for public testimony **(Attachment #2)**.

II. NEW LEGISLATION

- **Attachment #3: CDCAN Report: Governor Acts on 48 Bills – Signs 42 & Vetoes 6; Signs SB 577, SB 1093, and AB 1595**

Governor Jerry Brown has until midnight September 30, 2014 to sign, veto or allow to become law without his signature, bills passed by the Legislature in its final days of the 2014 Legislature session that adjourned August 30, 2014. Governor Brown recently signed several bills impacting the Developmental Disabilities Services System **(Attachment #3)**.

Link SB 577 (Pavley) – Community-Based Vocational Development Demonstration Project

- Requires Department of Development Services (DDS), contingent upon receiving federal funding, to create a four-year demonstration project for vocational development services.
- Up to five regional centers may participate.
- Individuals may participate for up to 75 hours per quarter, for up to two years. An additional two years is permissible if the IPP team determines that the participant is making progress.
- The hourly rate for community based vocational development services established at $40/h.

Link SB 1093 (Liu) – Cultural Competency and Data Reporting

- Adds residence type, subcategorized by age, race or ethnicity, and primary language to the data collection requirements.
- Requires regional centers to hold stakeholder meetings concerning the demographic data separately from any meetings of its Board of Directors. Meetings are to be scheduled at times/places designed to result in a high turnout by the public and underserved communities.
- Annual reports must be made to the Department of Developmental Services (DDS) on the stakeholder meetings, with specified information required to be included.

Link AB 1595 (Chesbro) – State Council On Developmental Disabilities Restructuring

- Brings the structure and workings of the SCDD into compliance with federal requirements.
- The role and scope of the 13 Area Boards on Developmental Disabilities are recast as discretionary regional offices of the SCDD, operating under the direction and policies of the SCDD.
- A number of activities required of either SCDD or the newly structured regional offices have been removed from law due to a federal prohibition

Link AB 1522 (Gonzalez) – Sick leave

- This bill is of particular relevance to regional center service providers
- Employees (including temporary and seasonal workers) who work at least 30 days in a year with an employer are owed sick leave, at a rate of one hour leave per 30 hours worked.
- The bill would authorize an employer to limit an employee's use of paid sick days to 24 hours or 3 days in each year of employment.
- Sick leave accrual may be limited to 48 hours/6 days. This correlates to the one-year rollover of accrued leave.
- Sick pay is the same as regular pay.
- Accrual begins effective July 1st, 2015 for all current employees.

III. NEW CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) RULES FOR HOME AND COMMUNITY BASED SERVICES (HCBS) Waiver

- **Attachment #4: CMS Informational Bulletin**
- **Attachment #5: CMS Fact Sheet: Home and Community Based Services**
- **Attachment #6: CMS Fact Sheet: Summary of Key Provisions of the Home and Community Based Services (HCBS) Settings Final Rule**
- **Attachment #7: Summary of Key Provisions of the 1915(c) Home and Community Based Services (HCBS) Waiver Final Rule**

- **Attachment #8: Summary of Key Provisions of the 1915(i) Home and Community Based Services (HCBS) State Plan Option**
- **Attachment #9: HCBS Statewide Transition Plan**
- **Attachment #10: CMS Statewide Transition Plan Tool Kit for Alignment With the HCBS Final Regulation's Setting Requirements**
- **Attachment #11: CDCAN Report: State Releases for Public Comment Draft Statewide Transition Plan to Implement Major Changes to MediCaid HCBS Waivers**
- **Attachment #12: TCRC Task Force on CMS Final Rule for HCBS Waiver**
- **Attachment #13: GGRC Transformation Institute: A Tale of Two Organizations**

On March 17, 2014 the Centers for Medicaid and Medicare Services (CMS) final rule pertaining to Home and Community Based Services that applies to 1915(c) Waiver services as well as 1915(i) SPA services went into effect. These changes could have significant impact on the future of the Developmental Services landscape. While states have some time to modify their services depending on when their next Waiver or SPA applications are due, the final rule clarifies:

- Home and community-based settings requirements to apply to all services delivery, not just to residential settings. This includes day and work settings.
- Participants in HCBS services should be integrated into the community to the same degree that non-participants in HCBS services are. More guidance on isolating settings can be found here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Settings-that-isolate.pdf

Link

- New standards for home and community-based settings defined "by the nature and quality of individuals' experience" rather than by "what they are not"
- The requirement for choice of provider in provider owned or controlled settings
- The responsibility of the state rather than the provider for ensuring private room and roommate choice
- Service planning must be done through a person-centered planning process (additional CMS guidance on this will follow)

Full text of the rule is available for download here:
Link https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider.

Informational Bulletin **(Attachment #4)** and several fact sheets addressing Overview of Regulation **(Attachment #5),** 1915(c): Changes to HCBS Waiver Program **(Attachment #6),** 1915 (i): Key Provisions for HCBS State Plan Option **(Attachment #7)** and Summary of Key Provisions of the HCBS Settings Final Rule **(Attachment #8)** provide additional detailed information regarding the changes.

CMS offered a webinar on this information. The PowerPoint presentation from that training can be downloaded here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Final-Rule-Slides-01292014.pdf
Link

Additionally, the US Department of Labor in conjunction with CMS conducted a webinar regarding the implications of the new rule on day and employment services. Slides from that webinar as well as a video archive can be accessed here:
Link http://www.leadcenter.org/webinars/implications-hcbs-final-rule-non-residential-settings-impact-new-hcbs-guidance-employment-day-services

The California Department of Health Care Services (DHCS), the agency that oversees the State's MediCaid Program called "Medi-Cal" took an official step toward implementation of the new CMS rules by releasing for public comment a draft Statewide Transition Plan (STP) that includes outlining the overall statewide process, what state departments are involved and what specific waivers and services are impacted. The DHCS has been collaborating with partner departments including the Department of Developmental Services (DDS), the California Department of Aging (CDA), the California Department of Health (CDH) and others to draft the initial draft STP for public stakeholder input **(Attachments #9-#11).** In addition to the specific stakeholder process for the statewide draft STP, individual state departments including DDS will also release in the near future individual HCBS waiver STPs for public stakeholder input

Tri-Counties Regional Center (TCRC) has formed a joint CMS Final Rule Task Force with TCRC service providers to attempt to stay abreast of all the changes taking place in this area and to work together with the TCRC service providers to prepare for the eventual implementation of the myriad new changes required by CMS. The first meeting of the newly formed task force is scheduled to take place on October 2, 2014 from 9-10 am in Santa Barbara. All TCRC service providers are welcome to participate **(Attachment #12).** Additionally, Golden Gate Regional Center (GGRC) is planning to hold a one day workshop that will focus in part on the CMS final Rule changes and the impact it will have on Developmental Services. The GGRC event is scheduled to take place on November 20, 2014 from 10 am – 5pm at the California State Office Building, 1515 Clay Street, Oakland, CA **(Attachment #13).**

Tri-Counties Regional Center and Association of Regional Center Agencies (ARCA) will continue to monitor these changes as they unfold, particularly as CMS releases additional guidance on service planning, as well as specific details regarding what this rule means for non-residential settings.

IV. MEDI-CAL SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDER

- **Attachment #14: CMS Informational Bulletin on Medicaid Coverage of Services to Children with Autism Spectrum Disorder**
- **Attachment #15: State Plan Amendment to CMS to Add ABA as a Medi-Cal Benefit**
- **Attachment #16: DCHS Letter to Medi-Cal Managed Care Plans on Implementation of ABA as a Medi-Cal Benefit**
- **Attachment #17: ARCA Comments on the Draft State Plan Amendment for Medi-Cal Behavioral Health Treatment**

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) issued guidance that requires states to cover Behavioral Health Services (BHS) including Applied Behavioral Analysis (ABA) for individuals under age 21 with Autism Spectrum Disorder (ASD) through their Medicaid plans **(Attachment #14)**. The California Department of Health Care Services (DHCS) will be holding a series of stakeholder meetings to discuss the implementation of new Medi-Cal benefits for individuals under age 21 with ASD on 9/4/14, 10/21/14, 11/18/14, 12/19/14, and 1/13/15. For more information about these meetings go to:
Link http://www.dhcs.ca.gov .

DHCS has issued two draft documents that they are seeking comment on from stakeholders. The first is the State Plan Amendment (SPA), which when finalized will be submitted to CMS to add ABA as a Medi-Cal benefit **(Attachment #15)**. The second is a draft letter to managed care Medi-Cal plans that outlines how they should implement new services for individuals with ASD **(Attachment #16)**. Included in this document is a provision that allows individuals already receiving services through regional centers to continue receiving those services until there is a transition plan developed by DHCS and Department of Developmental Services (DDS). ARCA has submitted written comments to DHCS on the draft SPA **(Attachment #17)**.

While Medi-Cal funded BHT is a positive development, many questions and concerns remain about how this new benefit will affect children who are part of California's Regional Center System. Issues related to transition from Regional Center funded services to Medi-Cal funded services, choice of service providers through Medi-Cal, adequate Medi-Cal rates for service providers, and timeliness of services are some of the issues that need further clarification.

In preparation for implementing expanded Medi-Cal services for individuals under age 21 with ASD, ARCA is planning on meeting with DDS on October 1, 2014 to discuss the myriad of issues pertaining to this transition, including seeking written guidance for regional centers from DDS as the oversight entity for regional centers. In the interim, TCRC has begun to confer with the local Medi-Cal health plans in the Tri-Counties area that consist of CenCal Health in Santa Barbara and San Luis Obispo Counties and Gold Coast Health that serves Ventura County. TCRC will continue to confer with and provide guidance to TCRC ABA providers on the transition plan as new information becomes available. TCRC will continue to serve individuals eligible for regional center services and needing BHT services until the local health plans are adequately ready and able to assume responsibility for providing BHT services.

V. QUESTIONS & ANSWERS

Attachment #1

Omar Noorzad - ARCA - CommunityConnect: Show us the (lack of) money!

From: Daniel at ARCA<dsavino@arcanet.org>
To: Omar<onoorzad@tri-counties.org>
Date: 9/26/2014 11:00 AM
Subject: ARCA - CommunityConnect: Show us the (lack of) money!

Fixing our system starts with your advocacy!

View this email in your browser

ARCA

Our Next Fight - The Budget!

Service providers, regional centers, advocates, and families uniting around funding issues.

Just a few months ago, you were with us for the triumphant conclusion of a two-year push to renew Early Start. Thousands of children will soon be receiving life-changing early interventions. But California's developmental services system is underfunded and in a crisis!

That's why service providers, families and persons served, regional centers, and the Lanterman Coalition are pushing for immediate action to solve this serious problem. And our first chance is just under two weeks away! We need you to join us in Los Angeles on Thursday, October 9th, for a special Senate hearing titled *The Lanterman Act: Promises and Challenges*, and share your story of how inadequate funding is hurting you. Show them the (lack of) money!

The Senate Human Services Committee, chaired by Senator Jim Beall, wants to hear from persons served by regional centers, their families, service providers, and regional centers about the how budget freezes and cuts have affected services and supports. If you've ever wanted to tell the decision-makers your story, but couldn't get to Sacramento, this is your chance!

Join us at 1:30 p.m. Thursday October 9th, in Session Room 350 at the L.A. City Hall (Board of Public Works), on 200 North Spring Street, Los Angeles. [EXTRA: Click here for a street map, public parking options, or all local parking options.]

Can't join us but still want to share your story? Look up who your legislators are, contact them directly and urge them to support an increase in funding for developmental services **and** a

comprehensive review of the way our system's budget is calculated. Also, send us a copy of the email so we can share it with the Committee before the hearing! If you do, please contact us by Wednesday, October 8th.

Never testified at a hearing? Not sure how to prepare, or what to talk about? This guide, tailored to this event, will give you some basics!

ARCA has prepared two documents detailing the history of cuts/freezes and their effect on services. Learn more with this two-page summary!

Restoring the Promise of the Lanterman Act

In the past five years, the Health and Human Services Agency, with its 20 Departments, Offices, Boards, and Committees, took **$2 billion** in cuts. $1 billion fell on **a single department - Developmental Services**. That hurts all of us, and is very risky, as history shows. Federal funds provide about half the budget for serving people with developmental disabilities, but they come with strings attached. In 1997, California failed a "federal compliance audit" - we came up short on one of those stings. It ended up costing the state nearly $1 billion in federal money!

Today, almost $1.5 billion is in jeopardy because of inadequate state funding for providers and regional centers. Underfunding means centers can't comply with caseload ratios, and providers can't meet service expectations. To avoid another loss of federal money, a stop-gap repair and a long-term solution (reality-based funding) are needed.

With your advocacy, together we can make our voice heard, and begin to restore the promise of the Lanterman Act.

Our mailing address is:
ARCA
915 L Street, Suite 1440
Sacramento, CA 95814

Attachment #2

From: Marty Omoto - CDCAN (CA Disability Community Action Network)<martyomoto@rcip.com>
To: <onoorzad@tri-counties.org>
Date: 9/12/2014 4:41 PM
Subject: CDCAN REPORT (SEP 12 2014): Developmental Services Task Force Meets Oct 8th - Focus on Finding Ways to Strengthen Community System for People with DD

CDCAN Disability and Senior Rights Report: Developmental Services Task Force Headed by California Health & Human Services Agency Secretary Dooley To Look Ways to Strengthen Community-Based Services and Supports for People with Developmental Disabilities Will Meet October 8th -

CDCAN DISABILITY RIGHTS REPORT
CALIFORNIA DISABILITY/SENIOR COMMUNITY ACTION NETWORK
SEPTEMBER 12, 2014 – FRIDAY AFTERNOON
Advocacy Without Borders: One Community – Accountability With Action
CDCAN Reports go out to over 65,000 people with disabilities, mental health needs, seniors, people with traumatic brain and other injuries, people with MS, Alzheimer's and other disorders, veterans with disabilities and mental health needs, families, workers, community organizations, facilities and advocacy groups including those in the Asian/Pacific Islander, Latino, American Indian, Indian, African-American communities; policymakers, and others across the State.
Sign up for these free reports by going to the CDCAN website. Website: www.cdcan.us (http://www.cdcan.us/)
To reply to THIS Report write:
Marty Omoto at martyomoto@rcip.com (mailto:martyomoto@rcip.com) or martyomoto@att.net (mailto:martyomoto@att.net) [new email - will eventually replace current martyomoto@rcip address]
Twitter: martyomoto
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549

STATE CAPITOL UPDATE:
DEVELOPMENTAL SERVICES TASK FORCE HEADED BY SECRETARY DIANA DOOLEY WILL HOLD SECOND MEETING ON OCTOBER 8 - WEDNESDAY - 10 AM TO 4 PM IN SACRAMENTO TO LOOK AT WAYS TO STRENGTHEN COMMUNITY SERVICES & SUPPORTS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

SACRAMENTO, CA [CDCAN LAST UPDATED 09/12/2014 – 02:19 PM] – The Brown Administration's "Developmental Services Task Force" – formerly the "Future of the Developmental Centers Task Force" – and chaired by California Health and Human Services Agency Secretary Diana Dooley, will hold its second meeting on October 8^th, Wednesday from 10:00 AM to 4:00 PM at the California Department of Health Care Services building at 1700 K Street, First Floor Conference Room in Sacramento, CA 95814. A conference phone line is also available (see below) for persons not able to attend. The meetings of the task force are open to the public – and public comment will be taken at the meeting and from persons on the phone at the end of the meeting.
The task force, with its new focus to identify ways to strengthen the community-based services and supports for people with developmental disabilities, held its first meeting with its new mission on July 24^th in what could be a multi-year task force process. Issues to be examined by the task force, according to Secretary Dooley's original July 3, 2014 press release, will include community rates, the impact of new State and federal laws and regulations, and staffing levels at Regional Centers.
The original "Future of the Developmental Centers Task Force" (now renamed "Developmental Services Task Force") was headed by Dooley and composed of stakeholders and policymakers including the now retired Department of Developmental Services Director Terri Degadillo, that developed over 6 months in 2013, recommendations on the future of the State owned and operated facilities. That process and the recommendations were widely praised by advocates representing nearly every point of view on the issues of developmental centers and community-based services, and policymakers in both parties. As a result of the work of the task force, the Governor proposed – and the Legislature approved – several initial steps toward implementing those recommendations as part of the 2014-2015 State Budget. A series of just

completed regional stakeholder meetings in Fresno, Los Angeles and Sacramento was conducted by the Department of Developmental Services, headed by Director Santi Rogers to
receive input from stakeholders on implementation of several of the recommendations by the original "Future of the Developmental Centers Task Force".
Secretary Dooley, whose leadership on last year's task force was considered crucial and also widely praised by advocates and legislators from both parties, noted that "...this diverse group of stakeholders did a remarkable job coming together, setting aside differences, and producing a set of recommendations to chart a course for the future of the Developmental Centers...By working together and resisting the inclination toward either/or thinking, we can focus on appropriate services for people with developmental disabilities, regardless of setting."

MEETING INFORMATION
WHAT: Developmental Services Task Force
WHEN: October 8, 2014 – Wednesday
TIME: 10:00 AM to 4:00 PM
LOCATION: California Department of Health Care Services, 1700 K Street, First Floor Conference Room. Sacramento, CA 95814
CONFERENCE CALL LINE: 1-800-779-8389
PASSCODE (Verbally given to conference call operator): DS TASK FORCE.
FOR MORE INFORMATION: Jim Suennen, Associate Secretary, External Affairs, California Health and Human Services Agency at 916-651-8056 Email: Jim.Suennen@chhs.ca.gov (mailto:Jim.Suennen@chhs.ca.gov)

AGENDA EXPECTED TO INCLUDE ITEM ON "TRIAGE" OR "CRITICAL" ISSUES – TASK FORCE WILL LIKELY INCLUDE SOME NEW MEMBERS BUT WILL REMAIN LARGELY THE SAME IN SIZE
An agenda for the meeting has not yet been released (CDCAN will send out as soon as it is available) but is expected to include an agenda item to identify "triage" or critical issues that advocates at the July 24^th meeting said need to be part of the Governor's 2015-2016 State Budget that he will release on January 10^th.
The task force discussed on July 24th, approaches to looking at the issues regarding strengthening the community system and there was general agreement to look at issues in terms of "triage" or "critical", mid-term and longer term issues. No specific issues were identified in any of those categories at the July 24^th meeting. Dooley said that some of the issues could require a year or two fully identify, address and come up with possible solutions and recommendations. Secretary Dooley agreed to consider possible "triage" or "critical" issues saying that October was an important milestone in putting together the proposed budget for January, but made no further commitment beyond that.
At the July 24, 2014 meeting, Dooley said she wanted to generally retain the size and membership of the existing task force, with some possible replacements or additions of family members, persons with developmental disabilities receiving services, representatives of organized labor (unions) of community based providers and regional centers that also included cultural diversity. No public announcements have not yet been made regarding any changes to the task force membership, though some additions or changes are expected.

MAJOR CHANGE OCCURRING AND COMING
The task force is convening during a year with wide spread massive changes occurring to health and human services, including health care and long term services and supports for children and adults with developmental and other disabilities, the blind, mental health needs, seniors and low income workers and families.
The changes include the impact of federal regulations requiring in January 2015 the payment of overtime to various home care workers, including those funded through the 21 non-profit regional centers; impact of major increases in the State minimum wage and potential increases in various counties; a major shift by the federal government and State toward Medi-Cal managed care health plans to receive not only health benefits – but also, beginning in 8 counties under the "Coordinated Care Initiative", certain long term services and supports including In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP) – which will all become in those counties Medi-Cal managed care benefits; implementation of a new Statewide IHSS Public Authority in

those 8 counties; implementation of a new Medi-Cal behavioral health treatment benefit (effective September 15, 2014 – though those currently who are Medi-Cal eligible receiving regional center services will have a 12 month transition to the Medi-Cal benefit); and implementation of the new self determination program with a proposal to the federal government for matching funds expected by the end of October; and enforcement action by the Department of Public Health against the Intermediate Care Facility services at the Sonoma Developmental Center in Eldridge, California.
Overshadowing even those major changes and issues is the widespread impact of final regulations by the Centers on Medicare and Medicaid Services (CMS) issued last January that call for sweeping new mandatory requirements for the qualities of home and community-based settings under Medicaid home and community-based services waivers, Community First Choice Option, and home and community-based services under a state's Medicaid plan. Those regulations include outlining what existing community-based settings that are not home and community-based (and not eligible for funding), those settings presumed not to be home and community-based, and setting forth compliance and transition requirements for the states. Those new requirements could mean dramatic changes to a wide range of existing community-based services and programs including regional center funded residential services, site based programs, especially sheltered workshops, work activity programs, day programs – and also similar programs funded and operated in other systems receiving Medicaid funded home and community-based services.

RECONVENING TASK FORCE IMPLEMENTED THE GOVERNOR'S LINE ITEM VETO DIRECTIVE
The 2014-2015 State Budget, as passed by the Legislature and signed into law by Governor Edmund G. "Jerry" Brown, Jr., last June, included some major funding increases and restorations to health and human services, including child care providers; CalWORKs grants; payments with certain restrictions of overtime for home care workers including In-Home Supportive Service providers (effective January 2015), and restoration of eligibility to California's early intervention program – called "Early Start" (effective January 2015) - but held off on restoring or unfreezing community-based provider reimbursements funded through the 21 non-profit regional centers under the Department of Developmental Services (DDS); restoring rates for many fee-for-service Medi-Cal providers; or restoring previously eliminated Medi-Cal benefits, cut in 2009, among the many services hit by previous reductions over the years.
Both the Legislature and Governor cited continued uncertainty in revenues and spending levels as reasons to hold off on those funding increases this year.
When Governor Brown signed the package of bills making up the 20140-2015 State Budget on June 20th, he used his line item veto eliminating the appropriation that would have required the Department of Developmental Services to spend funds for a study with stakeholders to review and recommend an update of the core staffing formula for the 21 non-profit regional centers, and rate setting methodologies for community-based services and supports.
It was one of only two line item vetoes the Governor made in health and human services – none of which impacted direct services.
In his line item veto message, the Governor stated that he vetoed the additional expenditure approved by the Legislature because it would "...create a significant workload and cost pressures within a restrictive timeframe. Instead I am directing the Health and Human Services Agency to convene a task force to review both of these and other community issues that were identified in the Plan for the Future of the Developmental Centers."
The 6th recommendations by the task force called for the formation of a stakeholder group to look at ways to improve the community-based system of services.
Noting the Governor's line item veto message and directive, Secretary Dooley said she was reconvening the stakeholder group "...consistent with a recommendation in the [Future of the Developmental Centers Task Force] Plan and in response to Governor Brown's message in the recently signed Budget Act..." and "...will be charged with examining services for the developmentally disabled in the community."

TASK FORCE ORIGINALLY FOCUSED ON FUTURE OF DEVELOPMENTAL CENTERS
As previously reported, on July 3 2014, Secretary Dooley announced she would reconvene the existing Future of the Developmental Centers Task Force (now renamed "Developmental Services Task Force") that appears to largely carry out the 6th and final recommendation of the original task force on developmental centers, with a new focus to look at ways to strengthen that community-based system hit since the early 2000s with major reductions in services, cuts and freezes in rates and reimbursements.

That 6th recommendation, which the Legislature approved, stated that "Although outside the scope of this Task Force's charge, the Task Force expressed a desire for DDS [Department of Developmental Services] to form another task force to address ways to make the community system stronger. Among the many issues to be considered are: 1) the sufficiency of
community rates and the impact new State and federal laws and regulations may have; 2) whether current regulations can be streamlined, particularly affecting the licensing of facilities; and, 3) whether certain benefits received by DC [Developmental Center] residents as part of a DC closure process should be broadened to others in the community. These areas have a significant and long term impact on services for individuals with intellectual and developmental disabilities."
Some advocates and policy makers view the involvement of Dooley – the highest health and human service official in the Brown Administration - as a significant step toward addressing what advocates and policymakers from both parties have called a major crisis in the regional center funded community-based system serving tens of thousands of children and adults with developmental disabilities

LINKS TO ANNOUNCEMENT & OTHER RELATED INFORMATION
California Health and Human Services webpage on the task force's previous work on the future of developmental centers last year, including meeting agendas, documents and recordings and ALSO the new work of the renamed "Developmental Services Task Force":
http://www.chhs.ca.gov/pages/DCsTaskForce.aspx
A copy of the 59 page final recommendations of the task force submitted to the Legislature, on the same webpage can be viewed or downloaded at:
http://www.chhs.ca.gov/DCTFDocs/PlanfortheFutureofDevelopmentalCenters.pdf

FULL TEXT OF SECRETARY DOOLEY'S ORIGINAL JULY 3, 2014 ANNOUNCING RECONVENING OF TASK FORCE
Following is the complete text of Secretary Dooley's original announcement, released on July 3, 2014, regarding reconvening what was then called the "Future of the Developmental Centers Task Force" (now renamed the "Developmental Services Task Force":

California Health and Human Services Secretary Diana S. Dooley Reconvenes Task Force

Sacramento – California Health and Human Services Agency Secretary Diana S. Dooley today announced she will reconvene the Task Force that developed the Plan for the Future of Developmental Centers in California.
The Task Force includes consumers, consumer advocates, regional centers, community service providers, organized labor, families of developmental center residents, members of the Legislature and Department of Developmental Services staff.
Consistent with a recommendation in the Plan and in response to Governor Brown's message in the recently signed Budget Act, the Task Force will be charged with examining services for the developmentally disabled in the community.
The Task Force will develop recommendations to strengthen the community system in the context of a growing and aging population, resource constraints, availability of community resources to meet the specialized needs of clients, and past reductions to the community system. Issues to be examined will include community rates, the impact of new State and federal laws and regulations, and staffing levels at Regional Centers.
When the landmark Lanterman Developmental Disabilities Services Act was adopted in 1969 to establish community-based alternatives, California took the first step to develop a robust community system for those with developmental disabilities to live full, integrated lives in their local communities. Today, California serves approximately 275,000 individuals in the community system with a budget of $4.7 billion.
Secretary Dooley said in reconvening the Task Force, "This diverse group of stakeholders did a remarkable job coming together, setting aside differences, and producing a set of recommendations to chart a course for the future of the Developmental Centers. I believe this same group can build on that success by examining services in the community. By working together and resisting the inclination toward either/or thinking, we can focus on appropriate services for people with developmental disabilities, regardless of setting."
The first meeting of the Task Force will be July 24, 2014.

CDCAN/MARTY OMOTO YOUTUBE CHANNEL
A CDCAN (Marty Omoto) youtube channel was set up and has several videos dealing with current – and previous state budget issues, disability and senior rights, and advocacy.
To see the current videos, including March 2014 San Andreas Regional Center Aptos Legislative Breakfast, January 2014 panel discussion on services for adults with autism spectrum and related disorders in Palo Alto, and older videos including video of April 2003 march of over 3,000 people with developmental disabilities, families, providers, regional centers and others from the Sacramento Convention Center to the State Capitol (to attend and testify at budget hearing on proposed massive permanent cuts to regional center funded services, go to the CDCAN (Marty Omoto) Channel at:
https://www.youtube.com/channel/UCEySEyhnr9LQRiCe-F7ELhg
More videos – including new current videos (an interview with long time advocate Maggie Dee Dowling is planned, among others) – plus archive videos of past events – will be posted soon.

Photo of Marty Omoto, executive director of CDCAN
PLEASE HELP!!!!!!
SEPTEMBER 12, 2014 (Marty Omoto pictured left)
PLEASE HELP CDCAN CONTINUE ITS WORK
CDCAN Townhall Telemeetings, CDCAN Reports and Alerts and other activities cannot continue without YOUR help. To continue the CDCAN website and the CDCAN Reports and Alerts sent out and read by over 65,000 people and organizations, policy makers and media across the State, and to continue and resume CDCAN Townhall Telemeetings, trainings and other events, please send your contribution/donation (please make check payable to "CDCAN" or "California Disability Community Action Network" and mail to:
CDCAN – NEW MAILING ADDRESS:
1500 West El Camino Avenue Suite 499
Sacramento, CA 95833
[replaces 1225 8^th Street Suite 480, Sacramento, CA 95814]
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549 (replaced 916-212-0237)

Many, many thanks to all the organizations and individuals for their continued support that make these reports and other CDCAN efforts possible!

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Our mailing address is:
Marty Omoto - ** martyomoto@rcip.com (mailto:martyomoto@rcip.com)

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Attachment #3

From: Marty Omoto - CDCAN (CA Disability Community Action Network)<martyomoto@rcip.com>
To: <onoorzad@tri-counties.org>
Date: 9/19/2014 4:06 AM
Subject: CDCAN REPORT (SEP 19 2014): GOV ACTS ON 48 BILLS - SIGNS 42 & VETOES 6; SIGNS SB 577, SB 1093 & AB 1595

CDCAN Disability and Senior Rights Report: Governor Takes Action on 48 Bills Thursday (September 18th) Signing 42 & Vetoing 6 - Signs Several Bills Impacting People With Developmental Disabilities Including SB 577, SB 1093, AB 1595 Related to State Council on DD

CDCAN DISABILITY RIGHTS REPORT
CALIFORNIA DISABILITY COMMUNITY ACTION NETWORK
SEPTEMBER 19, 2014 – EARLY FRIDAY MORNING
Advocacy Without Borders: One Community – Accountability With Action
CDCAN Reports go out to over 65,000 people with disabilities, mental health needs, seniors, people with traumatic brain and other injuries, people with MS, Alzheimer's and other disorders, veterans with disabilities and mental health needs, families, workers, community organizations, facilities and advocacy groups including those in the Asian/Pacific Islander, Latino, American Indian, Indian, African-American communities; policymakers, and others across the State.
Sign up for these free reports by going to the CDCAN website. Website: www.cdcan.us (http://www.cdcan.us/)
To reply to THIS Report write:
Marty Omoto at martyomoto@rcip.com (mailto:martyomoto@rcip.com) or martyomoto@att.net (mailto:martyomoto@att.net) [new email - will eventually replace current martyomoto@rcip address]
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STATE CAPITOL UPDATE:
GOVERNOR TAKES ACTION THURSDAY ON 48 BILLS – SIGNS 42 AND VETOES 6; SIGNS SB 577 EMPLOYMENT PILOT BILL FOR PEOPLE WITH AUTISM AND DEVELOPMENTAL DISABILITIES; SIGNS STATE COUNCIL ON DEVELOPMENTAL DISABILITIES RESTRUCTURING BILL AB 1595; APPROVES SB 1093 ON NEW REQUIREMETNS FOR REGIONAL CENTERS IN CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES

SACRAMENTO, CA [CDCAN LAST UPDATED 09/19/2014 – 01:06 AM] -- Governor Edmund G. "Jerry" Brown, Jr. took action on 48 bills Thursday (September 18^th), signing 42 and vetoing 6.
Among those he acted on included several bills impacting children and adults with disabilities, mental health needs, seniors and low income families, including several key bills impacting people with developmental disabilities. The Governor has until midnight September 30^th to sign or veto bills passed by the Legislature in its final days of the 2014 Legislative session that adjourned August 30^th. Hundreds of bills remain on the Governor's desk.
Here is a CDCAN summary of bills that Governor Brown took action on yesterday (September 18^th): [CDCAN will provide a full report on all bills impacting people with disabilities, mental health needs, seniors and low income families each day and a wrap up of all bills acted on at the end of the month]:

DEVELOPMENTAL DISABILITIES & SERVICES RELATED BILLS
The bills acted on yesterday by the Governor impacting developmental services for children and adults with developmental disabilities, including those eligible with autism spectrum and related disorders:

AB 1595 – STATE COUNCIL ON DEVELOPMENTAL DISABILITIES
AUTHOR: Assemblymember Wes Chesbro (Democrat – Arcata)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Revises the responsibilities in State law of the State Council on Developmental Disabilities (SCDD), including restructuring the role and scope of California's 13 Area Boards on Developmental Disabilities, to

comply with the requirements of the federal Administration on Intellectual and Developmental Disabilities (AIDD), which has designated the SCDD as being at high risk and limited access to its $6.5 million grant. Also revises the authorization for the Department of Developmental Services (DDS) to contract with SCDD for advocacy services within its state developmental centers and makes other conforming changes.
PDF DOCUMENT COPY (60 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1551-1600/ab_1595_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

SB 577 – AUTISM AND OTHER DEVELOPMENTAL DISABILTIIES: EMPLOYMENT
AUTHOR: Sen. Fran Pavley (Democrat - Agoura Hills)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Requires the Department of Developmental Services (DDS), contingent upon receiving federal matching funds, to conduct a four-year demonstration project to determine whether community-based vocational development services will increase employment outcomes for eligible people with developmental disabilities and reduce purchase of service costs for working age adults.
Requires the development and semiannual review of a plan, as specified in the bill, if community-based vocational development services are determined to be necessary.
Establishes an hourly rate for community-based vocational development services for all services identified and provided in the plan.
Requires the Department of Developmental Services to publish a notice on their website when the demonstration project has been implemented, and to make determinations and notify the Legislature concerning the project's effectiveness, as specified in the bill, at the project's conclusion.
Establishes a sunset (ending) date of January 1, 2025 for the provisions of this bill.
PDF DOCUMENT COPY (4 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0551-0600/sb_577_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

SB 1093 – REGIONAL CENTERS: CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES
AUTHOR: Sen. Carol Liu (Democrat - La Canada Flintridge)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Requires regional centers to provide independent living skills services to an adult individual with developmental disabilities eligible for services.
Requires regional centers to hold the annual stakeholder meetings regarding data that includes residency type, race or ethnicity, and primary language, separately from any meetings of its board of directors and to schedule the meetings at times and locations designed to result in a high turnout by the public and underserved communities.
Would require that annual performance objectives be designed to, among other things, develop services and supports identified as necessary to meet identified needs, which includes culturally and linguistically appropriate services and supports.
Requires that, if a regional center is placed on probation, the Department of Developmental Services also provide a copy of the correction plan, timeline, and any other action taken by the department to a specified clients' rights advocacy contractor.
Also requires each regional center to annually report to the Department of Developmental Services (DDS) specified information regarding its implementation of these provisions and requires the reports to be posted on the Department of Developmental Services and each regional center's website by August 31 of each year.
PDF DOCUMENT COPY (6 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1051-1100/sb_1093_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

SB 1127 – MISSING SENIORS "SILVER ALERT": INDIVIDUALS WITH DEVELOPMENTAL DISABILITES AND COGNITIVE IMPAIRMENTS

AUTHOR: Sen. Norma J. Torres (Democrat – Pomona)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Existing State law authorizes a law enforcement agency, if a person is reported missing to the law enforcement agency, and that agency determines that certain requirements are met, including, among others, that the missing person is 65 years of age or older, to request the California Highway Patrol to activate a "Silver Alert" (similar to the "Amber Alert" for children).
Would include a missing person who is developmentally disabled or cognitively impaired among the persons who may be the subject of the State's existing "Silver Alert".
Would also delete the existing January 1, 2016 repeal date, which would make the "Silver Alert" and the provisions of this bill operate indefinitely.
PDF DOCUMENT COPY (2 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1101-1150/sb_1127_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

EDUCATION
While there were some other education finance related bills that the Governor took action on yesterday, this bill could have some impact on children with special needs and disabilities and their families:

AB 1993 – STUDENTS: BULLYING
AUTHOR: Assemblymember Steve Fox (Democrat – Palmdale)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Requires the Department of Education to develop an online training module regarding bullying.
PDF DOCUMENT COPY (1 PAGE) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1951-2000/ab_1993_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

HEALTH INCLUDING MEDI-CAL
Following are health related bills that could have some impact on people with disabilities, mental health needs, the blind, seniors and low income families, providers and workers:

AB 809 – TELEHEALTH
AUTHOR: Assemblymember Dan Logue (Republican – Marysville)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
This is an "urgency" bill that takes effect immediately upon signing of the bill.
Deletes a requirement that informed consent for telehealth must be made by a provider at the originating site where the patient is located, allows written consent to be provided, rather than requiring consent to be verbal, and clarifies that current telehealth law does not preclude a patient from receiving in-person health care delivery services after agreeing to receive services via telehealth.
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Took effect immediately upon approval of Governor and chaptering (filing) of the bill with the California Secretary of State.

AB 1755 – MEDICAL INFORMATION
AUTHOR: Assemblymember Jimmy Gomez (Democrat – Los Angeles)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Revises provisions of State law requiring licensed health facilities to prevent disclosure of patients' medical information by extending the deadline for health facilities to report unauthorized disclosures from five to 15 business days after unlawful or unauthorized access, use, or disclosure has been detected.
Authorizes the report made to the patient or the patient's representative to be made by alternative means, including email, as specified by the patient.
Extends the deadline when reporting is delayed for law enforcement purposes, as specified, from five to 15 days business days after the end of the delay.
Gives the Department of Public Health full discretion to consider all factors when determining whether to conduct investigations under the provisions of this bill.

PDF DOCUMENT COPY (4 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1751-1800/ab_1755_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

AB 2029 - INQUESTS: SUDDEN UNEXPLAINED CHILDHOOD DEATH
AUTHOR: Assemblymember Ken Cooley (Democrat - Rancho Cordova).
CDCAN SUMMARY (AS SENT TO GOVERNOR):
Defines "sudden unexplained death in childhood," and requires a coroner to notify the parent or a responsible adult of a child within the definition of the importance of taking tissue samples.
PDF DOCUMENT COPY (4 PAGES) OF BILL AS VETOED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2001-2050/ab_2029_bill_20140829_enrolled.pdf
LATEST ACTION 09/18/2014: VETOED by Governor
GOVERNOR'S VETO MESSAGE:
To Members of the California State Assembly:
I am returning Assembly Bill 2029 without my signature.
This bill would add a statutory definition of "sudden unexplained death in childhood" and require coroners to notify parents or responsible parties about the importance of taking tissue samples when such an unexplained death occurs.
Rather than creating a state mandate at this juncture, we should rely on coroners to use their best professional judgment to provide appropriate and relevant information to next of kin for this difficult circumstance.
Sincerely,
[SIGNED]
Edmund G. Brown, Jr.

AB 2214 – EMERGENCY ROOM PHYSICIANS AND SURGEONS CONTINUING EDUCATION: GERIATIC CARE
AUTHOR: Assemblymember Steve Fox (Democrat – Palmdale)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Enacts the "Dolores H. Fox Act" to require the Medical Board of California to consider including a course in geriatric care for emergency room physicians and surgeons as part of its continuing education requirements.
PDF DOCUMENT COPY (2 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2201-2250/ab_2214_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

SB 1012 – HEALING ARTS: LICENSURE REQUIREMENTS
AUTHOR: Sen. Mark Wyland (Republican - Escondido)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Increases the number of hours, from five to six, which a marriage and family therapist (MFT) trainee or intern and a professional clinical counselor (PCC) intern may count towards their weekly supervision requirement
PDF DOCUMENT COPY OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1001-1050/sb_1012_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

SB 1083 – PHYSICIAN ASSISTANTS: DISABILITY CERTIFICATIONS
AUTHOR: Senator Fran Pavley (Democrat - Agoura Hills)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Amends the "Physician Assistant Practice Act" to authorize a physician assistant (PA) to certify claims for disability insurance (DI), after performance of a physical examination by the PA and under the supervision of a physician and surgeon; expands the definition of "practitioner" to include PAs.
Requires the Employment Development Department (EDD) to implement these provisions on or before

January 1, 2017.
PDF DOCUMENT COPY (4 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1051-1100/sb_1083_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

SB 1116 – PHYSICIANS AND SURGEONS
AUTHOR: Sen. Norma J. Torres (Democrat - Pomona)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Requires the Medical Board of California and the Osteopathic Medical Board of California to develop a mechanism for a physician and surgeon to pay a voluntary contribution, at the time of application for initial licensure or biennial renewal, to the "Steven M. Thompson Physician Corps Loan Repayment Program" on or before July 1, 2015.
PDF DOCUMENT COPY OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1101-1150/sb_1116_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

SB 1465 – HEALTH: EMSA, MEDI-CAL PROVIDERS, HOME HEALTH AGENCIES
AUTHOR: Senate Health Committee
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
This is an "urgency" bill that takes effect immediately upon signing of the bill.
Requires county reports on the implementation and status of the Maddy Funds to be sent to the Emergency Medical Services Authority (EMSA) annually and requires the EMSA to compile and send a summary of the reports to the appropriate policy and fiscal committee in the Legislature.
Permits the Department of Health Care Services to cancel a Medi-Cal provider application review process if an application package is withdrawn at the request of the applicant or provider.
Extends the California Health Benefit Review Program from June 30, 2015, to December 31, 2015.
Requires the Department of Health Care Services to license a home health agency that applies for a Home Health Agency License and is accredited by an entity approved by the federal Centers for Medicare and Medicaid Services as a national accreditation organization, instead of the requirement that the home health agency be accredited by the Joint Commission on Accreditation of Healthcare Organization or the Community Health Accreditation Program.
Requires the San Francisco City and County health authority to establish a member advisory committee to advise the authority on issues of concern to the Medi-Cal recipients of services and would delete the requirement that one of the 2
persons nominated by the committee be a Medi-Cal recipient and instead require the 2 persons nominated by the committee to be enrolled in a health care program operated by the health authority, or be the parent or legal guardian of an enrollee.
Makes numerous other technical, clarifying changes to existing State law.
PDF DOCUMENT COPY (76 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1451-1500/sb_1465_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: This is an "urgency bill" and took effect immediately upon approval of Governor and chaptering (filing) of the bill with the California Secretary of State.

LEGAL ACCESS, LEGAL SERVICES AND COURTS
The following bills were acted on yesterday by the Governor related to the judicial system (courts), legal access, and criminal justice that could have some impact on people with disabilities, mental health needs, the blind, seniors and low income families.

AB 2370 – COURT INTERPRETERS
AUTHOR: Assemblymember Ed Chau (Democrat – Arcadia)
CDCAN SUMMARY (AS SENT TO GOVERNOR):
Requires a judge, in any proceeding in which the court appoints an interpreter who does not hold an interpreter certificate

for a designated language, or who is qualified to interpret using a non-designated language but is not registered, to have stated on the record a finding that a certified or registered interpreter is not available, the name of the interpreter, and a statement that he or she meets the specified qualification requirements and that the interpreter's oath was administered to the interpreter.
Requires a judge in any court proceeding, when using a certified or registered court interpreter, to have stated on the record the name of the interpreter, his or her current interpreter certification or registration number, the language to be interpreted, a statement that the certified or registered interpreter's identification has been verified by the court, and a statement that the interpreter's oath was administered to him or her, or that he or she has an oath on file with the court, as specified.
Requires certified or registered interpreters to state similar information for the record in depositions where a judge is not present, as specified.
PDF DOCUMENT COPY (3 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2351-2400/ab_2370_bill_20140918_chaptered.pdf
TEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

AB 2494 – COURTS: FRIVOLOUS ACTIONS OR PROCEEDINGS
AUTHOR: Assemblymember Ken Cooley (Democrat – Rancho Cordova)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Authorizes a trial court to, until January 1, 2018, award reasonable expenses incurred as a result of bad-faith actions or tactics that are "frivolous" or solely intended to cause unnecessary delay by deleting language that currently limits that authorization to actions or tactics arising from a complaint filed or proceeding initiated on or before December 31, 1994.
Requires parties who file motions for an award of costs for bad-faith actions or tactics to transmit to the California Research Bureau (CRB) a copy of various documents associated with the motions.
Requires the California Research Bureau to maintain a public record of all information transmitted related to each motion for at least three years, and, on or before January 1, 2017, requires the California Research Bureau to submit a report to the Legislature examining the impact and effect of the changes made by this bill's provisions
PDF DOCUMENT COPY (4 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2451-2500/ab_2494_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

AB 2746 – ATTORNEYS: ANNUAL MEMBERSHIP FEES (STATE BAR)
AUTHOR: Assembly Judiciary Committee
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Reauthorizes the State Bar of California (State Bar) to collect active membership dues of up to $390 for the year 2015.
PDF DOCUMENT COPY (3 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2701-2750/ab_2746_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

MENTAL HEALTH
The following bills deal with mental health related issues and were acted on by the Governor yesterday (September 18^th).

AB 2198 – MENTAL HEALTH PROFESSINALS: SUICIDE PREVENTION TRAINING
AUTHOR: Assemblymember Marc B. Levine (Democrat - Rafael)
CDCAN SUMMARY (AS SENT TO GOVERNOR):
Requires Psychologists, Licensed Marriage and Family Therapists (LMFTs), Licensed Education Psychologists (LEPs), Licensed Clinical Social Workers (LCSWs), and Licensed Professional Clinical Counselors (LPCCs) to complete either 1 5 or more hours of coursework during a degree program, or six or more hours of continuing education (CE) coursework as part of license renewal, in the areas of suicide assessment, management, and treatment, depending on the professional's date of graduation.

PDF DOCUMENT COPY (8 PAGES) OF BILL AS VETOED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2151-2200/ab_2198_bill_20140821_enrolled.pdf
LATEST ACTION 09/18/2014: VETOED by Governor
GOVERNOR'S VETO MESSAGE:
To Members of the California State Assembly:
I am returning Assembly Bill 2198 without my signature.
This bill would require certain mental health professionals to complete a training program in "suicide assessment, treatment, and management."
California has an extensive regulatory scheme that aims to ensure that California physicians, psychologists and counselors are skilled in the healing arts to which they have committed their lives. Rather than further legislating in this field, I would ask our licensing boards to evaluate the issues which this bill raises and take whatever actions are needed.
Sincerely
[Signed]
Edmund G. Brown, Jr.

SB 1054 – MENTALLY ILL OFFENDER CRIME REDUCTION GRANTS
AUTHOR: Senate President Pro Tem Darrell Steinberg (Democrat - Sacramento)
CDCAN SUMMARY OF BILL (AS SENT TO GOVERNOR):
Extends a recommendations plan deadline for the California Juvenile Justice Data Working Group (CJJDWG) and makes changes to the Mentally Ill Offender Crime Reduction (MIOCR) grant program.
PDF DOCUMENT COPY (4 PAGES) OF BILL AS SIGNED BY GOVERNOR:
http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1051-1100/sb_1054_bill_20140918_chaptered.pdf
LATEST ACTION 09/18/2014: SIGNED by the Governor.
NEXT STEPS: Becomes law January 1, 2015

CDCAN - MARTY OMOTO YOUTUBE CHANNEL
A CDCAN (Marty Omoto) youtube channel was set up and has several videos dealing with current – and previous state budget issues, disability and senior rights, and advocacy.
To see the current videos, including March 2014 San Andreas Regional Center Aptos Legislative Breakfast, January 2014 panel discussion on services for adults with autism spectrum and related disorders in Palo Alto, and older videos including video of April 2003 march of over 3,000 people with developmental disabilities, families, providers, regional centers and others from the Sacramento Convention Center to the State Capitol (to attend and testify at budget hearing on proposed massive permanent cuts to regional center funded services, go to the CDCAN (Marty Omoto) Channel at:
https://www.youtube.com/channel/UCEySEyhnr9LQRiCe-F7ELhg
More videos – including new current videos (an interview with long time advocate Maggie Dee Dowling is planned, among others) – plus archive videos of past events – will be posted soon.

Photo of Marty Omoto, executive director of CDCAN
PLEASE HELP!!!!!!
SEPTEMBER 19, 2014 (Marty Omoto pictured left)
PLEASE HELP CDCAN CONTINUE ITS WORK
CDCAN Townhall Telemeetings, CDCAN Reports and Alerts and other activities cannot continue without YOUR help. To continue the CDCAN website and the CDCAN Reports and Alerts sent out and read by over 65,000 people and organizations, policy makers and media across the State, and to continue and resume CDCAN Townhall Telemeetings, trainings and other events, please send your contribution/donation (please make check payable to "CDCAN" or "California Disability Community Action Network" and mail to:
CDCAN – NEW MAILING ADDRESS:
1500 West El Camino Avenue Suite 499
Sacramento, CA 95833
[replaces 1225 8^th Street Suite 480, Sacramento, CA 95814]
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549 (replaced 916-212-0237)

Many, many thanks to all the organizations and individuals for their continued support that make these

reports and other CDCAN efforts possible!

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Our mailing address is:
Marty Omoto - ** martyomoto@rcip.com (mailto:martyomoto@rcip.com)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: January 10, 2014

FROM: Cindy Mann
Director

SUBJECT: **Final Rule - CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers**

Today the Centers for Medicare & Medicaid Services (CMS) is pleased to announce the publication of an important final rule about home and community-based services (HCBS) provided through Medicaid's 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice. The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living. The rule is available at http://www.medicaid.gov/HCBS.

The final rule is a result of multiple rulemaking efforts over the last five years and consideration by CMS of input from thousands of stakeholders. This robust process helped CMS ensure that the regulation takes into account a wide range of stakeholder perspectives and the varying experiences across the states. There will be continued opportunities for stakeholder input as CMS works with states to implement this final rule.

CMS will offer opportunities for additional information, issuing additional guidance, and providing assistance as states begin implementing this final rule. We recognize that implementing this final rule may require states to evaluate and make adjustments in their current systems and that this process will take time. The final rule provides for a process that will allow states to implement this rule in a manner that will support continuity of services for Medicaid participants and minimize disruptions in service systems during implementation. This Informational Bulletin contains a brief overview of this transition process and the assistance available from CMS to assist states with the process.

Additional Information and Forthcoming Guidance

CMS is committed to ensuring that stakeholders have immediate access to information to help them understand the final rule. CMS has developed a website dedicated to providing information about the rule, available at http://www.medicaid.gov/HCBS. On this website, stakeholders can find links to fact sheets, questions and answers and other related resources. In addition, CMS will be holding a series of informational webinars over the next several weeks. The dates for these webinars can be

found on the website. CMS has also established a mailbox at HCBS@cms.hhs.gov and encourages you to submit questions to the mailbox.

As states begin implementation, CMS will provide additional information on a number of topics over the next several weeks and months. The information will be provided through additional Informational Bulletins and through revisions to the 1915(c) Waiver Technical Guide for regulatory changes for the 1915(c) HCBS Waivers, CMS will also be creating additional fact sheets and frequently asked questions (FAQs) to address questions from the public after they have had a chance to review the final rule.

Transition for Implementing Home and Community-Based Settings Requirements

CMS recognizes that states and providers may need time to implement the clarifying requirements about the characteristics of home and community-based settings. The final regulation provides for a transition process that will allow states to implement this rule in a manner that supports continuity of services for Medicaid participants and minimizes disruptions in service systems during implementation. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress towards compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing sub-regulatory guidance to provide the details regarding requirements for transition plans.

Assistance from CMS

CMS is committed to assisting states in implementing these rules and is available to work closely with individual states at the beginning and throughout the development of their transition plans. In addition, CMS is working to provide additional technical assistance resources to states and will provide information about these resources as soon as possible.

Many states have made significant progress in recent years to increase the availability and quality of home and community-based services. We believe the implementation of these rules will contribute

significantly to the quality and experience of participants in Medicaid HCBS programs and will further expand their opportunities for meaningful community integration in support of the goals of the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.*

We thank the many individuals and organizations who contributed input to these rules and look forward to the continuing dialogue with stakeholders as we work together to make them a reality.

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FACT SHEET

FOR IMMEDIATE RELEASE
January 10, 2014

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Home and Community Based Services

Overview

The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services. In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. Highlights of this final rule include:

- Provides implementing regulations for section 1915(i) State Plan HCBS, including new flexibilities enacted under the Affordable Care Act to offer expanded HCBS and to target services to specific populations;
- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs.
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs.

Key Provisions of the Final Rule

1915(c) Home and Community-Based Waivers

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. Specifically, it establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act, defines person-centered planning requirements, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs. For more detail, please refer to the 1915(c) fact sheet at http://www.medicaid.gov/HCBS.

Section 1915(i) Home and Community-Based State Plan Option

The final rule implements the section 1915(i) HCBS state plan option, including new flexibilities enacted under the Affordable Care Act that offer states the option to provide expanded home and community-based services and to target services to specific populations. In addition, the final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. For more detail, please refer to the 1915(i) fact sheet at http://www.medicaid.gov/HCBS.

Section 2601 of the Affordable Care Act: Five Year Period for Certain Demonstration Projects and Waivers

To simplify administration of the program for states, this final rule provides a five-year approval or renewal period for demonstration and waiver programs in which a state serves individuals who are dually eligible for Medicare and Medicaid benefits. This provision allows states to use a five year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).

Home and Community-Based Settings Requirements

The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The regulatory changes will maximize the opportunities for HCBS program participants to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid home and community-based services to provide alternatives to services provided in institutions. For more detail, please refer to the HCBS Settings fact sheet at http://www.medicaid.gov/HCBS.

The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress toward compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan that provides for the delivery of HCBS services within settings meeting the final rule's requirements, and CMS may approve transition plans for a period of up to five years, as supported by an individual state's circumstances.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year after the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will be issuing future guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

Attachment #6

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January 10, 2014

Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule
(CMS 2249-F/2296-F)

This final rule establishes requirements for the qualities of settings that are eligible for reimbursement for the Medicaid home and community-based services (HCBS) provided under sections 1915(c), 1915(i) and 1915(k) of the Medicaid statute. Over the past five years, CMS has engaged in ongoing discussions with stakeholders, states and federal partners about the qualities of community-based settings that distinguish them from institutional settings. As part of this stakeholder engagement, CMS issued an Advanced Notice of Proposed Rule Making (ANPRM) and various proposed rules relating to home and community-based services authorized by different sections of the Medicaid law, including 1915(c) HCBS waivers, 1915(i) State Plan HCBS and 1915(k) Community First Choice State Plans. CMS' definition of home and community-based settings has benefited from and evolved as a result of this stakeholder engagement.

In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

Overview of the Settings Provision

The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;

- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

The final rule excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.

The final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. If states seek to include such settings in Medicaid HCBS programs, a determination will be made through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution. This process is intended to be transparent and includes input and information from the public. CMS will be issuing future guidance describing the process for the review of settings subject to heightened scrutiny through either the transition plan process (for settings already in states' HCBS programs) or the HCBS waiver review processes (for settings states seek to add to their HCBS programs).

The final rule includes a transitional process for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states must evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual states' circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing future guidance on requirements for transition plans.

Changes in the Final Rule

The final rule clarifies several major areas of confusion and concern expressed by some commenters and stakeholders engaged throughout the processes of rulemaking regarding the requirements for home and community-based settings. While CMS' responses to the specific comments are contained in the preamble to the final rule, below is a summary of the areas of the rule that received the most feedback and the changes in the final rule that address those comments:

- **Disability specific complex**. The proposed rule included "disability specific complex" in the list of settings presumed not to be home and community-based settings. Comments on the proposed rules suggested that the phrase "disability specific complex" had multiple meanings, and the continued use of the phrase could have unintended adverse impacts on affordable housing options. To avoid those consequences, CMS eliminated the use of the phrase from the final rule. The final rule includes the following language on other settings: "any other setting that has the effect of discouraging integration of individuals from the broader community…"

- **Rebuttable presumption**. The proposed rule indicated that CMS would exercise a "rebuttable presumption" that certain settings are not home and community-based. CMS has removed this phrase from the final rule and clarified in the final rule that certain settings are presumed to have institutional characteristics and will be subjected to heightened scrutiny if states seek to include these settings in their HCBS programs. The rule allows the state to present evidence to CMS that the setting is actually home and community-based in nature and does not have the qualities of an institution. CMS will consider input from stakeholders, as well as its own reviews, in applying heightened scrutiny. This process will require the state to solicit public input.

- **Choice of provider in provider owned or controlled settings.** The final rule clarifies that when an individual chooses to receive home and community-based services in a provider owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle. For example, if a residential program provides habilitation connected with daily living and on-site supervision under a bundled rate, an individual is choosing the residential provider for those two services when he or she chooses the residence. The individual has free choice of providers for any other services in his or her service plan, such as employment services and other community supports.

- **Private rooms and roommate choice**. The final rule clarifies that states, as opposed to individual providers, have the responsibility for ensuring that individuals have options available for both private and shared residential units within HCBS programs. The rule further clarifies that an individual's needs, preferences and resources are relevant to his/her options for shared versus private residential units. Provider owned or operated residential settings will be responsible to facilitate individuals having choice regarding roommate selection within a residential setting.

- **Application of home and community-based settings requirements to non-residential settings.** CMS has clarified that the rule applies to all settings where HCBS are delivered, not just to residential settings. CMS will be providing additional information about how states should apply the standards to non-residential settings, such as day program and pre-vocational training settings.

Attachment #7

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January 10, 2014

Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule
(CMS 2249-F/2296-F)

Background

Section 1915(c) of the Social Security Act (the Act) authorizes the Secretary of Health and Human Services to waive certain requirements in Medicaid law in order for states to provide home and community-based services (HCBS) to meet the needs of individuals who choose to receive their long-term care services and supports in their home or community, rather than in institutional settings. Final rules were published to implement this law on July 25, 1994.

On June 22, 2009, CMS published an advance notice of proposed rulemaking (ANPRM) that indicated CMS' intention to initiate rulemaking on a number of areas within the section 1915(c) program. On April 15, 2011, CMS published the Notice of Proposed Rule Making (NPRM) that addressed many of the same issues raised in the ANPRM. The final rule published today reflects the significant public comment received over the extensive rulemaking process related to these issues.

This final rule makes several important changes to the 1915(c) HCBS waiver program. It provides states the option to combine existing waiver targeting groups. The rule also establishes requirements for home and community-based settings under the 1915(c), 1915(i) and 1915(k) Medicaid authorities, and person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i). In addition, it clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates. Finally, it describes the additional strategies available to CMS to ensure state compliance with the statutory provisions of section 1915(c) of the Act. Below is a summary of each of these provisions.

Flexibility to Combine Target Groups Under One Waiver

The final rule permits, but does not require, states to combine target groups within one HCBS waiver. Prior to that change, a single section 1915(c) HCBS waiver could only serve one of the following three target groups: older adults, individuals with disabilities, or both; individuals with intellectual disabilities, developmental disabilities, or both; or individuals with mental illness. This change will remove a barrier for states that wish to design a waiver that meets the needs of more than one target population. The rule includes a provision specifying that if a state chooses the option of more than one target group under a single waiver, the state must assure CMS that it is able to meet the unique service needs of individuals in each target group, and that each individual in the waiver has equal access to all needed services.

Home and Community-Based Settings

CMS' definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. Based on the comments received on the ANPRM and the proposed 1915(c) rules, and the comments received on the 1915(i) and 1915(k) proposed rules, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to the benefits of community living, including receiving services in the most integrated setting. For more detail, please refer to the HCBS Settings Fact Sheet, available at http://www.medicaid.gov/HCBS.

The final rule includes a transition period for states to ensure that their waivers and Medicaid state plans meet the HCBS settings definition. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final rule home and community-based settings definition, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plans meet the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing future guidance regarding transition plans.

Person-Centered Planning

The final rule specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative that the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and

the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

Duration, Extension and Amendment of Waivers

In this final rule, CMS added a new provision to clarify guidance regarding the effective dates of HCBS waiver amendments with substantive changes. Substantive changes include, but are not limited to, changes in eligible populations; constriction of service, amount, duration, or scope; and other modifications as determined by the Secretary. The rule also adds regulatory language that waiver amendments with substantive changes may only take effect on or after the date when the amendment is approved by CMS. Substantive changes also must be accompanied by information on how the state has assured smooth transitions and minimal adverse impact on individuals impacted by the change.

In addition, the final rule includes a new provision to ensure that states provide public notice when they propose substantive changes to their methods and standards for setting payment rates for services. The final rule also includes a provision directing that states establish public input processes specifically for waiver changes.

Strategies to Ensure Compliance with Statutory Assurances

A primary concern in the oversight of 1915(c) HCBS waivers is the health and welfare of the individuals served within the programs. Section 1915(f) of the Act requires the Secretary to monitor implementation of waivers to assure compliance with all requirements and provides for termination of waivers where the Secretary has found noncompliance. This authority and the process for termination of waivers are addressed in this final rule. CMS has included provisions that describe additional strategies that CMS may employ to ensure state compliance with the requirements for a waiver.

Attachment #8

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January 10, 2014

Fact Sheet: Summary of Key Provisions of the Final Rule for 1915(i) Home and Community-Based Services (HCBS) State Plan Option
(CMS 2249-F/2296-F)

Background

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(i) to the Social Security Act (the Act) providing states the option to offer home and community-based services, previously available only through a 1915(c) HCBS waiver, through the state's Medicaid state plan. As originally enacted, states could only serve individuals eligible under the State plan with incomes at or below 150 percent of the Federal poverty level (FPL) or below and could offer some, but not all, HCBS services and supports available through 1915(c) HCBS waivers. In addition, states were not able to target 1915(i) state slan HCBS to particular populations within the state.

The Affordable Care Act expanded coverable services under 1915(i) to include any of the HCBS permitted under section 1915(c) HCBS waivers, certain services for individuals with mental health and substance use disorders and other services requested by a state and approved by the Secretary of Health and Human Services. In addition, the changes support ensuring the quality of HCBS, require states to offer the benefit statewide and enable states to target 1915(i) State Plan HCBS to particular groups of participants but not limit the number of participants who may receive the benefit. CMS published a proposed rule on May 4, 2012 for these 1915(i) provisions. This final rule responds to the public comments received on those proposed rules.

In addition to the above provisions, the final rule also establishes a set of requirements for home and community-based settings under the 1915(i), 1915(c) and 1915(k) Medicaid authorities, and a set of person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i).

Home and Community-Based Settings

CMS' definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. Based on the comments received on the 1915(c) advance notice of proposed rulemaking (ANPRM), the proposed 1915(c) rule, and the comments received on the 1915(i) and 1915(k) proposed rules, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to the benefits of

community living, including receiving services in the most integrated setting. For more detail, please refer to the HCBS Settings Fact Sheet available at http://www.medicaid.gov/HCBS.

The final rule includes a transition period for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that the specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing sub-regulatory guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

HCBS Statewide Transition Plan

The California Department of Health Care Services (DHCS) is developing a Statewide Transition Plan (STP) as a result of the new Federal Home and Community-Based (HCB) Setting requirements effective March 17, 2014. These regulations are CMS 2249-F and CMS 2296-F, which affect 1915(i) and 1915(c) HCB Services Waivers. Pursuant to the new rules, the State must develop an STP within 120 days of submission of any Waiver amendment or renewal. This trigger date was initiated with the submission of the Multipurpose Senior Services Program (MSSP) Waiver renewal on August 22, 2014. Please note there will be individual Waiver Transition Plans, and additional stakeholder input processes, required to be submitted to the Centers for Medicare and Medicaid Services (CMS) by March 16, 2015. Further, all 1915(i) and 1915(c) Waivers must be in full compliance with the new Federal rules by March 16, 2019.

DHCS has been working with partner agencies, including The Department of Developmental Services (DDS), the California Department of Aging (CDA), the California Department of Public Health (CDPH), and other interested parties to develop a STP draft for public and stakeholder input. The State has been reviewing all 1915(i) and 1915(c) Waiver services and provider-controlled residential settings for compliance with the new HCB Setting requirements.

The initial draft (September 19, 2014) of the STP that outlines the various services and identifies the specific provider types in the 1915(i) and 1915(c) that DHCS, DDS, CDA and CDPH consider needing special focus to ensure compliance. The State invites stakeholders to assist in the assessment of HCB Setting compliance with Federal requirements, and welcomes interested parties into the stakeholder input process for a transparent and effective transition of these critical Medi-Cal programs.

- Draft HCBS Statewide Transition Plan (PDF)

Stakeholder Comments

DHCS will review and analyze all stakeholder comments and will revise the STP accordingly. DHCS will post the STP on September 19, 2014 which initiates the 30-day public comment period. After our first STP stakeholder call, DHCS will post the revised STP for stakeholder review and final comments. After reviewing final public input, DHCS

intends to post the final STP on the DHCS website and submit the STP to CMS by December 20, 2014.

- The first stakeholder call will be scheduled for October 21, 2014, 10am – 12pm.
  - The call in number is: 888-829-8671 Participant passcode: 7335142

- The second stakeholder call will be scheduled for December 2, 2014, 10am – 12pm.
  - The call in number is: 888-829-8671 Participant passcode: 7335142

Public Comments

- The first public comment period will begin September 19, 2014 through October 19, 2014.

- The second public comment period will begin October 27, 2014 through November 26, 2014.

Summary of stakeholder comments and minutes from stakeholder calls will be posted online in tandem with revised STP drafts. Please submit all comments to: STP@dhcs.ca.gov.
We look forward to working with our stakeholders to ensure compliance with the new Federal rules. Please note that conference call dates, times, and phone numbers may change. Please check the website for any such changes.

Foreword

Background – 1915(c) Waivers

The Federal government authorized the "Medicaid 1915(c) Home and Community-Based Services (HCBS) Waiver program" in 1981 under Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35). It is codified in section 1915(c) of the Social Security Act. The original legislative intent of the HCBS Waiver program was to slow the growth of Medicaid (Medi-Cal in California) spending by providing services in less expensive settings. In order to contain costs, the federal legislation limited waiver services to individuals who would be institutionalized if the services were not provided. However, the costs of those waiver services cannot be higher than what they would cost in an institutional setting.

The law permitted states to waive certain Medicaid program requirements and in doing so, deviate from Medicaid requirements, such as providing services only in certain geographic areas ("waive statewideness"). The HCBS Waiver program also allowed states flexibility to offer different types of services to individuals with chronic disabilities. Prior to this, with the origin of Medicaid in 1965, beneficiaries could only receive comprehensive long-term care in institutional settings ("budget neutrality").

The initial waiver application is approved by the Centers for Medicare & Medicaid Services (CMS) for three years with additional renewal applications needing to be approved every five years. The waiver can be designed for a variety of targeted diagnosis-based groups including individuals who are elderly, and those who have physical, developmental, or mental health disabilities, or other chronic conditions such as Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The waiver can be designed to offer a variety of services including case management, personal attendant services, adult day health care services, habilitation services, day treatment services, psychosocial rehabilitation services, mental health services, and other services specifically requested by the state. 1915(c) HCBS waivers have subsequently become mechanisms for many states, including California, to provide Medicaid-funded community-based, long-term care services and supports to eligible beneficiaries.

Background – 1915(i) State Plan

The Deficit Reduction Act of 2005 (DRA) gave states starting January 1, 2007 a new option to provide HCBS through a state plan amendment (SPA). Once approved by CMS, 1915(i) SPAs do not need to be renewed nor are they subject to some of the same requirements of waivers; for example, budget neutrality. Under this option, states set their own eligibility or needs-based criteria for providing HCBS. States are allowed to establish functional criteria in relation to certain services. The DRA provision eliminated the skilled need requirement and allowed states to cover Medicaid beneficiaries who have incomes no greater than 150 percent of the federal poverty level and who satisfy the needs-based criteria. The Patient Protection and Affordable Care Act of 2010 created several

amendments including elimination of enrollment ceilings, a requirement that services must be provided statewide, and other enrollment changes.

In early January 2014, CMS announced it had finalized important rules that affect HCBS provided through Medicaid/Medi-Cal, and subsequently published the regulations in the Federal Register on January 16, 2014. The rules became effective 60 days from publication, or March 17, 2014. These regulations are CMS 2249-F and CMS 2296-F.

Issues addressed in this Plan

This Statewide Transition Plan will present ways in which the State of California will evaluate home and community-based (HCB) settings where 1915(c) waivers and 1915(i) state plan program services are currently available. If it is determined that there are settings that do not meet the final regulations' HCB settings requirements, such HCB settings will be required to make changes that will bring them into compliance.

Information included in this document includes:

- Overview of State Responsibility
- HCB Settings
    - Summary of New Federal Requirements
    - Requirements for Modification of Compliance
- Overview of HCBS Programs
    - Multipurpose Senior Services Program (MSSP) Waiver
    - HIV/AIDS Waiver
    - HCBS Waiver for Persons with Developmental Disabilities (DD) Waiver
    - Assisted Living Waiver (ALW)
    - Nursing Facility/ Acute Hospital Transition and Diversion (NF/AH) Waiver
    - In-Home Operations (IHO) Waiver
    - San Francisco Community Living Support Benefit (SFCLSB) Waiver
    - Pediatric Palliative Care (PPC) Waiver
- Existing Settings in HCB Programs – Review and Analysis
    - California Plan for Determination of HCB Setting Compliance

Overview of State Responsibility

The State's HCBS program administrative teams are comprised of employees from the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Developmental Services (DDS), and the California Department of Aging (CDA). The San Francisco Department of Public Health (SFDPH) administers a 1915(c) waiver in accordance with terms of an Agreement with DHCS.

Existing waivers and corresponding state administrative teams are as follows:

1. MSSP Waiver (0141), CDA, Long Term Care & Aging Services
2. HIV/AIDS Waiver (0183), CDPH, Office of AIDS

3. DD Waiver (0336), DDS, Community Services
4. ALW (0431), DHCS, Long-Term Care Division
5. NF/AH Waiver (0139), DHCS, Long-Term Care Division
6. IHO Waiver (0457), DHCS, Long-Term Care Division
7. SFCLSB Waiver (0855), SFDPH
8. PPC Waiver (0486), DHCS, Systems of Care Division

Existing 1915(i) SPAs 09-023A and 11-041 are administered by DDS.

HCB Settings

Prior to the final rule, HCB setting requirements were based on location, geography, or physical characteristics. The final rules define HCB settings as more process and outcome-oriented, guided by the consumer's person-centered service plan by:

1. Being integrated in and supporting full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. Giving individuals the right to select from among various setting options, including non-disability specific settings and an option for a private unit in a residential setting.
3. Ensuring individuals' rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizing autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.
5. Facilitating choice regarding services and supports, and who provides them.

For Medi-Cal provider-owned or controlled HCB settings, the provider must offer:

- A legally enforceable agreement between the provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protection against eviction.
- Privacy in units including lockable doors, choice of roommates and freedom to furnish and decorate units.
- Options for individuals to control their own schedules including access to food at any time.
- Individuals the freedom to have visitors at any time.
- A physically accessible setting.

Any modification(s) of the new requirements must be supported by a specific and individually assessed need and justified in the person-centered service plan. Documentation of all of the following is required:

- Identification of a specific and individualized assessed need.
- The positive interventions and supports used prior to any modification(s) to the person-centered plan.

- Less intrusive methods of meeting the need that have been tried but did not work.
- A clear description of the condition(s) that is directly proportionate to the specific assessed need.
- Review of regulations and data to measure the ongoing effectiveness of the modification(s).
- Established time limits for periodic reviews to determine if the modification(s) is still necessary or can be terminated.
- Informed consent of the individual.
- An assurance that interventions and supports will cause no harm to the individual.

Overview of HCBS Programs

California currently has two approved 1915(i) SPAs that allow the State to access federal financial participation for services provided to individuals with developmental disabilities who do not meet the institutional level-of-care criteria required for participation in the DD Waiver, which is described in greater detail below.

California currently administers eight 1915(c) HCBS waivers.

Descriptions of the individual waivers follow below.

- *Multipurpose Senior Services Program (MSSP) Waiver.* The objective of this program is to provide opportunities for frail seniors age 65 or older to maintain their independence and dignity in community settings by preventing or delaying avoidable nursing facility placement. Care management is the cornerstone of this waiver and involves beneficiary assessment; person-centered care planning; service arrangement, delivery and monitoring; as well as coordinating the use of existing community resources. The 39 MSSP sites maintain wait lists independently; average wait in days statewide is 91 (during 10/1/12 through 12/31/12). The current waiver was approved on July 1, 2009.

  MSSP Waiver provider types include all of the following:

  - Adult Day Care/ Support Center
  - Building Contractor or Handyman/Private Nonprofit or Proprietary Agency
  - Congregate Meals Setting
  - Home Health Agency
  - Licensed/Certified Professionals
  - Private Nonprofit or Proprietary Agency
  - Registered Nurse Care Manager (RN)
  - Social, Legal, and Health Specialists
  - Social Worker Care Manager
  - Title III (Older Americans Act)
  - Translators/Interpreters
  - Transportation Providers

- *HIV/AIDS Waiver.* The purpose of this waiver is to allow persons of all ages with mid- to late-stage HIV/AIDS to remain in their homes through a continuum of care designed to stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to institutional care in hospitals or nursing facilities. There is no waiting list for eligible beneficiaries. The current waiver was approved on January 1, 2012.

  HIV/AIDS Waiver provider types include all of the following:

  - Clinical Psychologist
  - Foster Parent
  - Home Health Agency
  - Licensed Clinical Social Worker
  - Local Pharmacy or Vendor
  - Marriage and Family Therapist
  - Masters Degree Nurse; Psychiatric and Mental Health Clinical Nurse Specialist or Psychiatric and Mental Health Nurse Practitioner
  - Private Nonprofit or Proprietary Agency
  - Registered Dietician
  - RN
  - Social Work Case Manager
  - Waiver Agency with Exception Approved by CDPH/Office of Aids

- *HCBS Waiver for Persons with Developmental Disabilities (DD Waiver).* The purpose of this waiver is to serve participants of all ages in their own homes and community settings as an alternative to placement in hospitals, nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF/DD). Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private non-profit corporations known as regional centers. Regional centers provide fixed points of contact in the community for persons with developmental disabilities and their families. The DD Waiver has been in operation since 1982 to assist in funding services for individuals who live in the community and who meet the ICF/DD level-of-care requirements. DD Waiver participants live in the setting of their choice, such as with their families, in their own homes or apartments, or in licensed settings. There is no waiting list for eligible beneficiaries. The current waiver was approved on March 29, 2012.

  DD Waiver provider types include all of the following:

  - Activity Center
  - Adaptive Skills Trainer
  - Adult Day Care Facility
  - Adult Development Center
  - Adult Residential Facility
  - Adult Residential Facility for Persons with Special Health Care Needs

- Associate Behavior Analyst
- Behavior Analyst
- Behavior Management Consultant
- Behavior Management Program
- Behavioral Technician/Para-professional
- Building Contractor or Handyman
- Camping Services
- Certified Family Home
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Client/Parent Support Behavior Intervention Training
- Clinical Psychologist
- Community-Based Training Provider
- Contractor
- Creative Arts Program
- Crisis Intervention Facility
- Crisis Team – Evaluation and Behavioral Intervention
- Dentist
- Dental Hygienist
- Dietitian; Nutritionist
- Dispensing Optician
- Driver Trainer
- Durable Medical Equipment Provider
- Facilitators
- Family Home Agency: Adult Family Home/Family Teaching Home
- Financial Management Services Provider
- Group Home
- Hearing and Audiology Facilities
- Home Health Agency
- Home Health Aide
- Independent Living Program
- Independent Living Specialist
- Individual (Landlord, Property Management)
- Individual or Family Training Provider
- In-Home Day Program
- Licensed Clinical Social Worker
- Licensed Psychiatric Technician
- Licensed Vocational Nurse (LVN)
- Marriage Family Therapist
- Occupational Therapist
- Occupational Therapy Assistant
- Optometrist
- Orthoptic Technician
- Parenting Support Services Provider
- Personal Assistant
- Personal Emergency Response Systems Provider
- Physical Therapist

- Physical Therapy Assistant
- Physician/Surgeon
- Psychiatrist
- Psychologist
- Public Transit Authority
- Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company
- Registered Nurse
- Residential Care Facility for the Elderly
- Residential Facility (Out-of-State)
- Respite Agency
- Small Family Home
- Social Recreation Program
- Socialization Training Program; Community Integration Training Program; Community Activities Support Service
- Special Olympics Trainer
- Speech Pathologist
- Sports Club: (e.g., YMCA, Community Parks and Recreation Program, Community-Based Recreation Program)
- Supported Employment
- Supported Living Provider
- Translators/Interpreters
- Transportation Providers
- Vehicle Modification and Adaptations
- Work Activity Program

- *Assisted Living Waiver (ALW).* This waiver offers eligible seniors and persons with disabilities age 21 and over the choice of residing in either a licensed Residential Care Facility for the Elderly or an independent publicly subsidized housing with Home Health Agency services as alternatives to long-term institutional placement. The goal of the ALW is to facilitate nursing facility transition back into community settings or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement. Eight care coordinator agencies serving seven counties independently maintain wait lists. The current waiver was approved on March 1, 2009.

  ALW provider types include all of the following:

  - Care Coordination Agency
  - Home Health Agency in Public Subsidized Housing
  - Residential Care Facility for the Elderly

- *Nursing Facility/Acute Hospital (NF/AH) Waiver.* This waiver combined three 1915(c) waivers into one waiver. The NF/AH Waiver offers services in the home to Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult

subacute, pediatric subacute, intermediate care facility for the developmentally disabled – continuous nursing care and Nursing Facility A/B levels of care with the option of returning and/or remaining in their home or home-like setting in the community in lieu of institutionalization. The current NF/AH Waiver was approved on January 1, 2012.

NF/AH Waiver provider types include all of the following:

- Durable Equipment Provider
- Employment Agency
- Home and Community-Based Continuous Care Facility
- Home Health Agency
- In-Home Support Services Public Authority
- Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing Care
- Licensed Clinical Social Worker
- Licensed Psychologist
- LVN
- Marriage Family Therapist
- Non-Profit or Proprietary Agency
- Personal Care Agency
- Private Nonprofit or Proprietary Agency
- Professional Corporation
- RN
- Waiver Personal Care Services Provider

- *In-Home Operations (IHO) Waiver.* This waiver serves eligible individuals who: 1) were previously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and who require direct care services provided primarily by a licensed nurse; or 2) have been receiving continuous care in a hospital for 36 months or longer and have physician-ordered direct care services that are greater than those available in the NF/AH waiver for the participant's level of care. The current waiver was approved on January 1, 2010 .

  IHO Waiver provider types include all of the following:

  - Durable Medical Equipment Provider
  - Employment Agency
  - Home and Community-Based Continuous Care Facility
  - Home Health Agency
  - In-Home Support Services Public Authority
  - Licensed Clinical Social Worker
  - Licensed Psychologist
  - LVN
  - Marriage Family Therapist
  - Personal Care Agency

- Private Nonprofit or Proprietary Agency
- Professional Corporation
- RN
- Waiver Personal Care Services Provider

- *San Francisco Community Living Support Benefit (SFCLSB) Waiver.* This waiver utilizes certified public expenditures for provision of waiver services to persons with disabilities age 21 and over who reside in the City and County of San Francisco and who are either homeless, residing in a nursing facility, or are at imminent risk of entering a nursing facility. Eligible individuals can move into licensed Community Care Facilities (CCFs) or Direct Access to Housing (DAH) sites (e.g., private homes). Services consist of care coordination, community living support benefits, and behavior assessment and planning in both CCFs and DAHs; and home delivered meals and environmental accessibility adaptions in DAH sites.

  SFCLSB Waiver provider types include all of the following:

  - Adult Residential Facility
  - Clinical Psychologist
  - Durable Medical Equipment Provider, Building Contractor or Handyman Private Nonprofit or Proprietary Agency
  - Home Delivered Meal/Meal Preparation Vendor
  - Home Health Agency
  - Licensed Clinical Social Worker
  - Marriage Family Therapist
  - Not-For-Profit Case Management Agency
  - Private Nonprofit or Proprietary Agency
  - Residential Care Facility for the Elderly
  - Therapist (Various Specializations)

- *Pediatric Palliative Care (PPC) Waiver.* This waiver offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. According to diagnosed need and an approved plan of care, services include: care coordination, expressive therapies, family training, individual and family caregiver counseling/bereavement services, pain and symptom management, personal care and respite care.

  PPC Waiver provider types include all of the following:

  - Agency Certified Nursing Assistant
  - Art Therapist
  - Associate Clinical Social Worker
  - Child Life Specialist
  - Congregate Living Health Facility
  - Home Health Agency

- Home Health Aide
- Hospice Agency
- Licensed Clinical Social Worker
- Licensed Psychologist
- LVN
- Masters Level Social Worker
- Massage Therapist
- Music Therapist
- RN

Existing Settings in HCBS Programs – Review and Analysis

California Plan for Determination of HCB Setting Compliance:

The standards, rules, regulations and other requirements for the following HCB settings will be analyzed and reviewed by DHCS, CDA, DDS and CDPH to determine the extent to which they comply with federal regulations. State departments will be responsible for ensuring appropriate provision of HCBS by all providers that serve Medi-Cal beneficiaries.

- Adult Family Home/Family Teaching Home
- Adult Residential Facility
- Adult Residential Facility for Persons with Special Health Care Needs
- Certified Family Home
- Congregate Living Health Facility
- Home and Community-Based Continuous Care Facility
- Foster Family Home
- Group Home
- Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing Care
- Residential Care Facility for the Elderly
- Residential Facility (Out-of-State)
- Small Family Home

The compliance determination process includes all of the following:

- An initial State-level assessment of standards, rules, regulations, and other requirements to determine if they are consistent with the federal requirements. This will be completed within six months of CMS approval of the Statewide Transition Plan.

- This State-level assessment will be conducted jointly by DHCS and the State Department(s) responsible for operating each Waiver with stakeholder input.

- Results of this assessment will be available for public comment and will be used to determine and develop the remedial strategies that may be necessary to ensure that

all HCB settings conform to the federal requirements.

- In addition to the State-level assessment, on-site evaluations of individual settings will be conducted as follows:
  - On-site evaluations will be conducted at all settings that, per CMS guidance, are presumed not to be HCB settings.
  - For all other settings, a representative random sample of on-site evaluations will be conducted.
  - It is anticipated that the on-site evaluations will be completed within one year of CMS approval of the assessment tool.

- The on-site evaluations will be conducted by a survey team that includes one or more of the following: State personnel, service recipients or their family members, case managers or other representatives of case management entities, representatives of consumer advocacy organizations, and/or other stakeholders.

- The responsibility for ensuring completion of these evaluations rests with the program staff as specified under the "Overview of State Responsibility" section of this document. The State will support the provision of training for all participants of survey teams to ensure that HCB settings are built around the person-centered plan approach and are compliant with the new federal requirements.

- DHCS will develop an assessment tool for use in the on-site evaluations of HCB settings. The assessment tool will include each new federal requirement that will be used to determine if the HCB setting meets or does not meet the required federal rule. The completed assessment tool will be maintained in the appropriate State file for each waiver and will be used to verify compliance at the time of CMS renewal of the HCBS waiver.

  Note: this assessment tool shall be developed and circulated for stakeholder comments no later than 60 days after CMS approval of this Statewide Transition Plan.

- The assessment tool will be forwarded to each HCB setting selected for evaluation with instructions to complete a self-assessment prior to the evaluation completed by the survey team. The completed assessment will be forwarded back to the Waiver program for review.

- Using the completed assessments, each selected HCB setting (selected from the list identified under the "California Plan for Determination of HCB Setting Compliance" subsection of this document) will be evaluated by a survey team described above.

- Written results of each survey will be forwarded back to the HCB setting with specific information regarding improvements that will be required in order to come into compliance with the federal requirements and a timeline for completion.

- Completed assessments for all settings, including documentation of any required follow-up actions as a result of the on-site evaluations, will be maintained in the appropriate State file for each waiver.

- An appeal process, to be developed, which allows the HCB setting to dispute the HCB setting's compliance or the need to comply with the specific requirement when the HCB setting determines the requirement is not applicable to the particular setting.

  Note: the appeal process shall be developed and circulated for stakeholder comments no later than 60 days after CMS approval of this Statewide Transition Plan.

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

- Progress on completion of this Statewide Transition Plan will be monitored at least every six months and will include public posting on the status with opportunity for public input.

Attachment #10

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Statewide Transition Plan Toolkit for Alignment with the Home and Community-Based Services (HCBS) Final Regulation's Setting Requirements

September 5, 2014

The following information is intended to suggest alternative approaches and considerations for states as they prepare and submit Statewide Transition Plans as required by the HCBS final regulation published January 16, 2014 (available at http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf). This toolkit relates specifically to the Federal requirements for residential and non-residential home and community-based settings. These regulatory requirements can be found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).

What is a Statewide Transition Plan?

The Statewide Transition Plan is the vehicle through which states determine their compliance with the regulation requirements for home and community-based settings at 42 CFR 441.301(c)(4)(5) and 441.710(a)(1)(2), and describe to CMS how they will comply with the new requirements. A Statewide Transition Plan includes the state's assessment of the extent to which its regulations, standards, policies, licensing requirements, and other provider requirements ensure settings that comport with the requirements outlined at 42 CFR 441.301(c)(4)(5) and 42 CFR 441.710(a)(1)(2). The Statewide Transition Plan also describes actions the state proposes to assure full and on-going compliance with the HCBS settings requirements, with specific timeframes for identified actions and deliverables.
The Statewide Transition Plan is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii).

Who Submits?

Each state operating a section 1915(c) waiver or a section 1915(i) state plan benefit that was in effect on or before March 17, 2014 is required to file a Statewide Transition Plan.

When to Submit?

The trigger for filing a Statewide Transition Plan is the state's first 1915(c) waiver or 1915(i) SPA renewed or amended between March 17, 2014 and March 16, 2015. A Statewide Transition Plan must be submitted within 120 days after the submission date of the first renewal or amendment. If a state does not submit an amendment or renewal between March 17, 2014 and March 16, 2015, the state must submit a Statewide Transition Plan no later than March 17, 2015. States must be in full compliance with the Federal requirements by the time frame approved in their Statewide Transition Plan, not to exceed March 17, 2019.

How can states determine alignment with the new Federal requirements on HCBS settings?

The purpose of the Statewide Transition Plan is to describe how the state will bring all pre-existing 1915(c) and 1915(i) programs into compliance with the home and community-based settings requirements at 42 CFR 441.301(c)(4)(5) and Section 441.710(a)(1)(2). To determine whether state transition actions are needed for compliance, CMS expects that states must first determine their current level of compliance with the settings requirements and provide a written description to CMS. Included in the written description should be the state's assessment of the extent to which its standards, rules, regulations, or other requirements comply with the Federal HCBS settings requirements and the description of the state's oversight process to ensure continuous compliance. The state may also assess individual settings/types of settings to further document their compliance.

Possible scenarios might include:

1) Upon conducting its compliance assessment, a state may determine that existing state standards meet the Federal settings requirement, the state's oversight process is adequate to ensure compliance, and, therefore, any settings currently approved under the state's standards meet the Federal settings requirement. In this scenario, the state describes its process for conducting the compliance review and the outcomes of that review; or

2) The state conducts its compliance review and determines that its standards may not meet the Federal settings requirements. In this scenario, the state includes in the Statewide Transition Plan the specific actions to be taken to come into compliance. These actions might include proposing new state regulations or revising existing ones; revising provider requirements; and conducting statewide provider training on the new state standards. The Statewide Transition Plan should also include the time frames for completing these actions, an estimate of the number of settings that likely do not meet the Federal settings requirement and the time frame necessary to bring individual settings into compliance.

In situations where the state standards do not coincide with the Federal standards, it is possible that specific settings are still in compliance with the Federal requirements. In this case, a state may choose to assess individual sites to determine which are/are not in compliance with the Federal standard. Such an assessment may impact the time frames proposed to bring settings into compliance; if so, the Statewide Transition Plan should include these additional actions and timeframes.

States may conduct specific site evaluations through a variety of standard processes including, but not limited to licensing reviews, provider qualification reviews, and support coordination visit reports. States may also engage individuals receiving services as well as representatives of consumer advocacy entities (such as long-term care ombudsman programs and protection and advocacy systems) in the assessment process.

States may conduct – or develop a tool for qualified entities to conduct – site specific evaluations of settings using the Federal requirements as a basis for the evaluation. Such evaluations may be conducted by entities including, but not limited to state personnel, case managers that are not associated with the agency operating the setting in which services are provided, licensing entities, Managed Care Organizations, individuals receiving home and community-based services, representatives of consumer advocacy entities such as long-term care ombudsman programs and/or protection and advocacy systems. States may also perform on-site assessments of a statistically significant sample of settings. When states do not have full knowledge of the settings in their system, CMS strongly encourages, at a minimum, a sampling approach to on-site reviews.

States may also administer surveys to providers to determine whether the settings in which those providers operate meet the home and community-based settings requirements. In this instance, providers could "self-assess" their compliance with the Federal requirements or provide information required by the state to make a determination of compliance. In either situation, states could perform assessments of individual settings to verify compliance. If providers indicate they do not meet the new requirements, states should include remediation strategies in the Statewide Transition Plan, including actions and associated time frames for bringing the programs/settings into compliance.

It should be noted that assessment of individual settings is not a substitute for ensuring that state standards, regulations, policies, and other requirements are consistent with Federal requirements and that the state has an oversight system in place to assure ongoing compliance with the requirements. In addition, where the state is submitting evidence that a setting presumed not to be home and community-based is in fact home and community-based and does not have the qualities of an institution, evidence of a site visit will facilitate the heightened scrutiny process.

The state's determination of compliance is the first step in Statewide Transition Plan development. The next step is developing and describing to CMS the state's actions to come into full compliance, including timelines and milestones.

What does CMS expect to see in a Statewide Transition Plan?

Presence of the following items will facilitate CMS review of the states' submitted plans:

- A detailed description of the state's assessment of compliance with the home and community-based settings requirements and a statement of the outcome of that assessment.
    - If the state determines on the basis of the review of current state regulations, standards, and policy that settings within the state are consistent with Federal settings requirements, the state should describe the process of the compliance assessment, the basis for the conclusion and the oversight (monitoring) process that ensures this. If the process of assessment

is not yet complete and has required, or will require, greater than six (6) months for review, the state must submit justification for the additional time frame.

- If the assessment is based on state standards, the state needs to provide their best estimate of the number of settings that: 1) fully align with the Federal requirements; 2) do not comply with the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals; 4) are presumptively non-home and community-based but for which the state will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (to be evaluated by CMS through the heightened scrutiny process). In instances where a system review identifies settings which are presumed not to be home and community-based (home and community-based) and the state intends to submit evidence that the setting is home and community-based and does not have institutional characteristics, CMS would expect an onsite assessment that supports the state's assertion.

- If the state conducts site specific evaluations, the state needs to provide the best estimate of the number of settings that 1) fully comply with the Federal requirements; 2) do not meet the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals; 4) are presumptively non-home and community-based but for which the state will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (to be evaluated by CMS through the heightened scrutiny process).

- A detailed description of the remedial actions the state will use to assure full compliance with the home and community-based settings requirements, including timelines, milestones and monitoring process. Remedial actions might include:
  - At the state level, remedial actions might include, but are not limited to, new requirements promulgated in statute, licensing standards or provider qualifications, revised service definitions and standards, revised training requirements or programs, plans to relocate individuals to settings that are compliant with the regulations, and a description of the state's oversight and monitoring processes.

  - At the provider level, remedial actions might include, but are not limited to, changes to the facility or program operation to assure that the Medicaid beneficiary has greater control over critical activities like access to meals,

engagement with friends and family, choice of roommate, and access to activities of his/her choosing in the larger community, including the opportunity to seek and maintain competitive employment.

- If the state decides to submit evidence to CMS for the application of the heightened scrutiny process for settings that are presumed not to be home and community-based, the Statewide Transition Plan should include evidence sufficient to demonstrate the setting does not have the characteristics of an institution and does meet the home and community-based setting requirements. Evidence of a site visit by the state, or an entity engaged by the state, will facilitate the heightened scrutiny process. CMS will consider input from the state, information collected during the public input process, and information provided by other stakeholders as part of the heightened scrutiny process. CMS may also conduct individual site visits as well.

- When relocation of beneficiaries is part of the state's remedial strategy, the Statewide Transition Plan should include:
    - An assurance that the state will provide reasonable notice to beneficiaries and due process to these individuals;
    - A description of the timeline for the relocation process;
    - The number of beneficiaries impacted; and
    - A description of the state's process to assure that beneficiaries, through the person-centered planning process, are given the opportunity, the information, and the supports to make an informed choice of an alternate setting that aligns, or will align, with the regulation, and that critical services/supports are in place in advance of the individual's transition.

- The time frame and milestones for state actions, including assessment and remedial actions. If state standards must be modified in order to effect changes in the state system, the state should propose a reasonable time frame for making the modifications. If the state intends to conduct an assessment after adopting new standards, the state should provide information on how, in the interim, the state will communicate the need for change, educate providers, inform individuals and families, and establish a time frame for the activities. The state must also include a complete timetable for coming into full compliance.

- A description of the public input process, with a summary of public comments, including the full array of comments whether in agreement or not with the state's determination of the system-wide compliance and/or compliance of specific settings/types of settings; a summary of modifications to the Statewide Transition Plan made in response to public comment; and in cases where the state's determination differs from public comment, the additional evidence and rationale the state used to confirm the determination (e.g. site visits to specific settings).

- The URL where the Statewide Transition Plan is posted.

When is Public Input Required?

Prior to filing with CMS, a state must seek input from the public on the state's proposed Statewide Transition Plan, providing no less than a 30-day period for that input. CMS encourages states to seek input from a wide range of stakeholders representing consumers, providers, advocates, families, and other related stakeholders. The process for individuals to submit public comment should be convenient and accessible for all stakeholders, particularly individuals receiving services. CMS requires states to post the Statewide Transition Plans on their website in an easily accessible manner and include a website address for comments. At least one additional option for public input, such as public forums, is required.

The Statewide Transition Plan requirements set forth that states must provide evidence of two statements of public notice and requests for public input, the timeframe for public input (which verifies that a minimum of 30-days was afforded for public review and comment), and a description of the public input process. To accomplish this, the state could include in the Statewide Transition Plan the actual date of the public notice, the processes used for providing the public notice (e.g., publication in newspapers, announcement via websites) and how public input was received (e.g., testimony, web response).

When filing the Statewide Transition Plan with CMS, the state must provide a summary of public comments, including comments that agree/disagree with the state's determinations about whether types of settings meet the home and community-based settings requirements; a summary of modifications to the Transition Plan made in response to public comment; and in the case where the state's determination differs from public comment, the additional evidence and the rationale the state used to confirm the determination (e.g. site visits to specific settings). At the time the state files the Statewide Transition Plan with CMS, the state must simultaneously post the submitted plan on the state's website. The URL for that posting should be included in the Statewide Transition Plan submission to CMS.

The state must also provide an assurance that the Statewide Transition Plan, with any modifications made as a result of public input, is posted for public information no later than the date of submission to CMS, and that all public comments on the Statewide Transition Plan are retained and available for CMS review for the duration of the transition period or approved waiver, whichever is longer.[1]

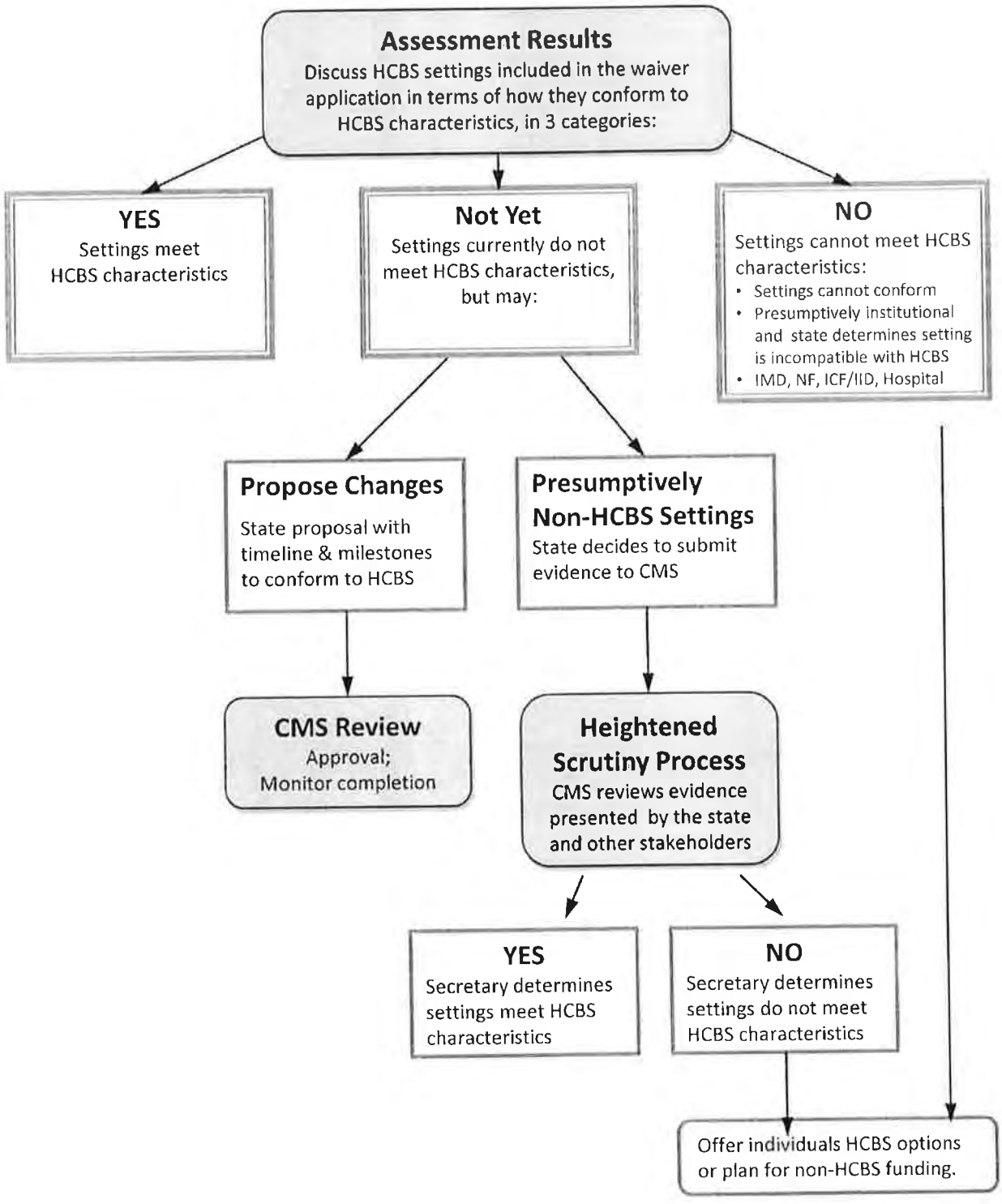
CMS wishes to ensure that states recognize the changes in the public notice and public input process required by this regulation. States must ensure the document is posted and, in the case of public forums, available or distributed for comment. States can use summary documents or offer explanations of contents of the Statewide Transition Plan, in addition to the document itself. However, the state must ensure the full Statewide Transition Plan is available to the

[1] States filing waiver renewals or amendments to existing 1915(c) waivers require a public input process in addition to the public input process for the embedded waiver specific Transition Plan. A state could use one public input process to meet both requirements.

public for comment, including individuals receiving services, individuals who could be served, and the full stakeholder community. While a state may find meetings held with selected representatives of types of stakeholder useful, such meetings will not be sufficient to demonstrate adequate notification or input.

Finally, consistent with the Toolkit document "STEPS TO COMPLIANCE FOR HCBS SETTINGS REQUIREMENTS IN A 1915(c) WAIVER and 1915(i) SPA" substantive changes in a Statewide Transition Plan will require public comment. For example, when a state submits an amendment or modification to a Statewide Transition Plan where additional assessment has resulted in a change in the findings or where the state adds more specific remedial action and milestones, the state must incorporate the public notice and input process into that submission. CMS believes it would be very helpful for the states to use public input in the assessment of the state's progress on the milestones approved in the Statewide Transition Plan. Therefore, states are strongly encouraged to describe their process for ensuring ongoing transparency and input from the stakeholders in the Plan.

STEPS TO COMPLIANCE FOR HCBS SETTINGS REQUIREMENTS IN A 1915(c) WAIVER and 1915(i) SPA



Exploratory Questions to Assist States in Assessment of Residential Settings

This optional tool is provided to assist states in assessing whether the characteristics of Medicaid Home and Community-based Services, as required by regulation, are present. The information is organized to cite anticipated characteristics and to provide suggested questions to determine if indicators of that characteristic are present.

Characteristics that are expected to be present in all home and community-based settings and associated traits that individuals in those settings might experience.

1. **The setting was selected by the individual.**
    - **Was the individual given a choice of available options regarding where to live/receive services?**
    - **Was the individual given opportunities to visit other settings?**
    - **Does the setting reflect the individual's needs and preferences?**
2. **The individual participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.**
    - **Does the individual regularly access the community and is s/he able to describe how s/he accesses the community, who assists in facilitating the activity and where s/he goes?**
    - **Is the individual aware of or does s/he have access to materials to become aware of activities occurring outside of the setting?**
    - **Does the individual shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community, as the individual chooses?**
    - **Does the individual come and go at any time?**
    - **Does the individual talk about activities occurring outside of the setting?**
3. **The individual is employed or active in the community outside of the setting.**
    - **Does the individual work in an integrated community setting?**
    - **If the individual would like to work, is there activity that ensures the option is pursued?**
    - **Does the individual participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual?**
4. **The individual has his/her own bedroom or shares a room with a roommate of choice.**
    - **Was the individual given a choice of a roommate?**
    - **Does the individual talk about his/her roommate(s) in a positive manner?**

- Does the individual express a desire to remain in a room with his/her roommate?
- Do married couples share or not share a room by choice?
- Does the individual know how s/he can request a roommate change?

5. The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.
   - How is it made clear that the individual is not required to adhere to a set schedule for waking, bathing, eating, exercising, activities, etc.?
   - Does the individual's schedule vary from others in the same setting?
   - Does the individual have access to such things as a television, radio, and leisure activities that interest him/her and can s/he schedule such activities at his/her convenience?
6. The individual controls his/her personal resources.
   - Does the individual have a checking or savings account or other means to control his/her funds?
   - Does the individual have access to his/her funds?
   - How is it made clear that the individual is not required to sign over his/her paychecks to the provider?
7. The individual chooses when and what to eat.
   - Does the individual have a meal at the time and place of his/her choosing?
   - Can the individual request an alternative meal if desired?
   - Are snacks accessible and available anytime?
   - Does the dining area afford dignity to the diners and are individuals not required to wear bibs or use disposable cutlery, plates and cups?
8. The individual chooses with whom to eat or to eat alone.
   - Is the individual required to sit at an assigned seat in a dining area?
   - Does the individual converse with others during meal times?
   - If the individual desires to eat privately, can s/he do so?
9. Individual choices are incorporated into the services and supports received.
   - Do Staff ask the individual about her/his needs and preferences?
   - Are individuals aware of how to make a service request?
   - Does the individual express satisfaction with the services being received?
   - Are requests for services and supports accommodated as opposed to ignored or denied?
   - Is individual choice facilitated in a manner that leaves the individual feeling empowered to make decisions?
10. The individual chooses from whom they receive services and supports.
    - Can the individual identify other providers who render the services s/he receives?
    - Does the individual expresses satisfaction with the provider selected or has s/he asked for a meeting to discuss a

change?

- Does the individual know how and to whom to make a request for a new provider?

11. The individual has access to make private telephone calls/text/email at the individual's preference and convenience.
    - Does the individual have a private cell phone, computer or other personal communication device or have access to a telephone or other technology device to use for personal communication in private at any time?
    - Is the telephone or other technology device in a location that has space around it to ensure privacy?
    - Do individuals' rooms have a telephone jack, WI-FI or ETHERNET jack?
12. Individuals are free from coercion.
    - Is information about filing a complaint posted in an obvious location and in an understandable format?
    - Is the individual comfortable discussing concerns?
    - Does the individual know the person to contact or the process to make an anonymous complaint?
    - Can the individual file an anonymous complaint?
    - Do the individuals in the setting have different haircut/hairstyle and hair color?
13. The individual, or a person chosen by the individual, has an active role in the development and update of the individual's person-centered plan.
    - Is/are the individual/chosen representative(s) aware of how to schedule Person-Centered Planning meetings?
    - Can the individual explain the process to develop and update his/her plan?
    - Was the individual present during the last planning meeting?
    - Did/does the planning meeting occur at a time and place convenient for the individual to attend?
14. The setting does not isolate individuals from individuals not receiving Medicaid HCBS in the broader community.
    - Do individuals receiving HCBS live/receive services in a different area of the setting separate from individuals not receiving Medicaid HCBS?
    - Is the setting in the community among other private residences, retail businesses?
    - Is the community traffic pattern consistent around the setting (e.g. individuals do not cross the street when passing to avoid the setting)?
    - Do individuals on the street greet/acknowledge individuals receiving services when they encounter them?
    - Are visitors present?
    - Are visitors restricted to specified visiting hours?
    - Are visiting hours posted?
    - Is there evidence that visitors have been present at regular frequencies?
    - Are there restricted visitor's meeting area?
15. State laws, regulations, licensing requirements, or facility protocols or practices do not limit individuals' choices.

- **Do State regulations prohibit individuals' access to food at any time?**
- **Do State laws require restrictions such as posted visiting hours or schedules?**
- **Are individuals prohibited from engaging in legal activities?**

16. The setting is an environment that supports individual comfort, independence and preferences.

- **Do individuals have full access to typical facilities in a home such as a kitchen with cooking facilities, dining area, laundry, and comfortable seating in the shared areas?**
- **Is informal (written and oral) communication conducted in a language that the individual understands?**
- **Is assistance provided in private, as appropriate, when needed?**

17. The individual has unrestricted access in the setting.

- **Are there gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting?**
- **Are individuals receiving Medicaid Home and Community-Based services facilitated in accessing amenities such as a pool or gym used by others on-site?**
- **Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting or if they are present are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction?**

18. The physical environment meets the needs of those individuals who require supports.

- **For those individuals who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.?**
- **Are appliances accessible to individuals (e.g. the washer/dryer are front loading for individuals in wheelchairs)?**
- **Are tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably?**

19. Individuals have full access to the community.

- **Do individuals come and go at will?**
- **Are individuals moving about inside and outside the setting as opposed to sitting by the front door?**
- **Is there a curfew or other requirement for a scheduled return to the setting?**
- **Do individuals in the setting have access to public transportation?**
- **Are there bus stops nearby or are taxis available in the area?**
- **Is an accessible van available to transport individuals to appointments, shopping, etc.?**
- **Are bus and other public transportation schedules and telephone numbers posted in a convenient location?**
- **Is training in the use of public transportation facilitated?**
- **Where public transportation is limited, are other resources provided for the individual to access the broader**

community?

20. The individual's right to dignity and privacy is respected.
    - Is health information about individuals kept private?
    - Are schedules of individuals for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view?
    - Are individuals, who need assistance with grooming, groomed as they desire?
    - Are individuals' nails trimmed and clean?

21. Individuals who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences.
    - Are individuals wearing bathrobes all day long?
    - Are individuals dressed in clothes that fit, are clean, and are appropriate for the time of day, weather, and preferences?

22. Staff communicates with individuals in a dignified manner.
    - Do individuals greet and chat with staff?
    - Do staff converse with individuals in the setting while providing assistance and during the regular course of daily activities?
    - Does staff talk to other staff about an individual(s) as if the individual was not present or within earshot of other persons living in the setting?
    - Does staff address individuals in the manner in which the person would like to be addressed as opposed to routinely addressing individuals as 'hon' or 'sweetie'?

Characteristics that are expected to be present in all provider owned or controlled home and community-based settings and associated traits that individuals in those settings might experience.

1. Modifications of the setting requirements for an individual are supported by an assessed need and justified in the person-centered plan.
    - Does documentation note if positive interventions and supports were used prior to any plan modifications?
    - Are less intrusive methods of meeting the need that were tried initially documented?
    - Does the plan includes a description of the condition that is directly proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the modification, informed individual consent, and assurance that the intervention will not cause the individual harm?

2. **Individuals have privacy in their sleeping space and toileting facility.**
    - **Is the furniture arranged as individuals prefer and does the arrangement assure privacy and comfort?**
    - **Can the individual close and lock the bedroom door?**
    - **Can the individual close and lock the bathroom door?**
    - **Do staff or other residents always knock and receive permission prior to entering a bedroom or bathroom?**
3. **The individual has privacy in his/her living space.**
    - **Are cameras present in the setting?**
    - **Is the furniture arranged as individuals prefer to assure privacy and comfort?**
    - **Do staff or other residents always knock and receive permission prior to entering an individual's living space?**
    - **Does staff only use a key to enter a living area or privacy space under limited circumstances agreed upon with the individual?**
4. **The individuals have comfortable places for private visits with family and friends.**
    - **Is the furniture arranged to support small group conversations?**
5. **Individuals furnish and decorate their sleeping and/or living units in the way that suits them.**
    - **Are the individuals' personal items, such as pictures, books, and memorabilia present and arranged as the individual desires?**
    - **Do the furniture, linens, and other household items reflect the individual's personal choices?**
    - **Do individuals' living areas reflect their interests and hobbies?**
6. **There is a legally enforceable agreement for the unit or dwelling where the individual resides.**
    - **Does the individual have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement?**
    - **Does the individual know his/her rights regarding housing and when s/he could be required to relocate?**
7. **Individuals are protected from eviction and afforded appeal rights in the same manner as all persons in the State who are not receiving Medicaid HCBS.**
    - **Do individuals know their rights regarding housing and when they could be required to relocate?**
    - **Do individuals know how to relocate and request new housing?**
    - **Does the written agreement include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant laws?**

Attachment #11

From: Marty Omoto - CDCAN (CA Disability Community Action Network)<martyomoto@rcip.com>
To: <onoorzad@tri-counties.org>
Date: 9/22/2014 8:09 AM
Subject: CDCAN REPORT (SEP 22 2014): State Releases For Public Comment Draft Statewide Transition Plan to Implement Major Changes to Medicaid HCBS Waivers

CDCAN Disability and Senior Rights Report: State Releases - Draft Statewide Transition Plan to Implement New Federal Regs for Medicaid Home & Community Based Services Waivers - Major Changes Could Impact Wide Range of Community Based Services Under Departments of Developmental Services, Aging, Public Health, Health Care Services

CDCAN DISABILITY RIGHTS REPORT
CALIFORNIA DISABILITY COMMUNITY ACTION NETWORK
SEPTEMBER 22, 2014 – MONDAY MORNING
Advocacy Without Borders: One Community – Accountability With Action
CDCAN Reports go out to over 65,000 people with disabilities, mental health needs, seniors, people with traumatic brain and other injuries, people with MS, Alzheimer's and other disorders, veterans with disabilities and mental health needs, families, workers, community organizations, facilities and advocacy groups including those in the Asian/Pacific Islander, Latino, American Indian, Indian, African-American communities; policymakers, and others across the State.
Sign up for these free reports by going to the CDCAN website. Website: www.cdcan.us (http://www.cdcan.us/)
To reply to THIS Report write:
Marty Omoto at martyomoto@rcip.com (mailto:martyomoto@rcip.com) or martyomoto@att.net (mailto:martyomoto@att.net) [new email - will eventually replace current martyomoto@rcip address]
Twitter: martyomoto
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549

STATE CAPITOL UPDATE:
SWEEPING CHANGES COMING FOR MANY MEDICAID HOME & COMMUNITY BASED WAIVER SERVICES ACROSS NATION AS STATES TAKE STEPS TO COMPLY WITH NEW REGULATIONS
- DEPARTMENT OF HEALTH CARE SERVICES RELEASES FOR PUBLIC COMMENT PROPOSED 12 PAGE DRAFT STATE TRANSITION PLAN TO FEDS THAT OUTLINES HOW CALIFORNIA WILL IMPLEMENT NEW FEDERAL REGULATIONS IMPACTING ITS MEDICAID HOME AND COMMUNITY BASED WAIVER SERVICES
- SCHEDULES TWO PUBLIC STAKEHOLDER CONFERENCE CALLS FOR PUBLIC ON DRAFT STATE TRANSITION PLAN FOR OCT 21 & DEC 2 FROM 10 AM TO 12 NOON
- FURTHER STATEHOLDER MEETINGS ON INDIVIDUALS WAIVERS IMPACTING WAIVER SERVICES UNDER DEPARTMENTS OF AGING, DEVELOPMENTAL SERVICES, PUBLIC HEALTH TO BE SCHEDULED – IMPACT COULD BE ENORMOUS ESPECIALLY TO SITE BASED PROGRAMS & RESIDENTIAL SERVICES

SACRAMENTO, CA [CDCAN LAST UPDATED 09/22/2014 – 05:30 AM] – Sweeping changes are coming across the nation including California for several Medicaid funded special programs, - known as "Home and Community Based Services Waivers" - that will impact a wide range of long-time community-based services and programs serving hundreds of thousands of children and adults with disabilities – including developmental, mental health needs, with major steps being taken by the states in recent weeks to implement new federal regulations that became effective March 17, 2014.
The new federal regulations which redefine what home and community-based services are allowable for federal funding, combined with changes mandated by the federal Affordable Care Act, and implementation of the "Coordinated Care Initiative" in 8 counties that are shifting health care services and long term services and supports to Medi-Cal managed care plans, represent the biggest changes to California's Medi-Cal program since it was established in 1965.
The new federal regulations include a requirement for the states to publicly release a statewide transition

plan on how it will implement the federal regulations – and also require the states to involve the public in the process. In general, states have five years (from the March 17, 2014 effective date of the federal regulations) to fully transition and comply with the new rules with their existing waivers – but must be in full compliance when submitting any new waivers or a proposed change in their existing Medicaid State Plan.

Medicaid waivers are programs that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under Medicaid rules. California has a number of Medicaid waivers that fund a wide range of programs, services and supports for children and adults with disabilities (including developmental), mental health needs, the blind and seniors – including services funded through the 21 non-profit regional centers, In-Home Operations Waiver , Nursing Facility/Acute Hospital Waiver, Multipurpose Senior Services Program (MSSP) and more.

DEPARTMENT OF HEALTH CARE SERVICES RELEASES DRAFT STATE TRANSITION PLAN TO IMPLEMENT NEW REGULATIONS

In California, the Department of Health Care Services, the agency that oversees State's massive Medicaid program called "Medi-Cal", - the largest in the nation - took an official step moving toward implementation, with the release for public comment of a "Draft Statewide Transition Plan" – required by the federal regulations - that includes outlining the overall statewide process, what state departments are involved and what specific waivers and services are impacted.

The Department of Health Care Services said it has been working with partner agencies, including the Department of Developmental Services (DDS), the California Department of Aging (CDA), the California Department of Public Health (CDPH), and others to develop the initial draft Statewide Transition Plan for public stakeholder input. The State has been reviewing all impacted Medi-Cal waivers (1915(i) and 1915(c) Waiver services and provider-controlled residential settings) for compliance with the new federal requirements.

The department has scheduled public comments periods for its initial draft plan released September 19^th and also a public comment period for a revised draft that will be released later in October, with also two public stakeholder conference calls scheduled to receive further comments and to answer questions. The department indicated that a summary of stakeholder public comments and minutes from the two public stakeholder conferences calls will be posted on the department's webpage with the revised drafts of the Statewide Transition Plan.

The Department of Health Care Services, after receiving and reviewing public comments from its initial and revised draft plans, intends to submit the final version to the federal Centers on Medicare and Medicaid Services (CMS) by December 20, 2014. The final Statewide Transition Plan will be posted on the department's webpage (see below for link).

In addition to the specific stakeholder process for the Draft Statewide Transition Plan, the Department of Health Care Services, with the Departments of Aging, Developmental Services and Public Health, indicated that there will be in the coming weeks and months, also individual Home and Community Based Services Waiver Transition Plans – such as a plan specific for the Home and Community Based for Developmental Services that fund the majority of regional center funded services and supports for children and adults with developmental disabilities - that will be drafted that will each have additional public stakeholder input processes. No draft plans or specific dates for meetings or conference calls have yet been officially announced yet, but are expected soon. Those additional specific plans for each waiver impacted – which require a public comment period - has to be submitted to the federal Centers for Medicare and Medicaid Services (CMS) by March 16, 2015.

WHAT ARE THE NEW FEDERAL REGULATIONS?

[CDCAN Note: Certain exceptions to some of the requirements, especially those regarding residential services could be permitted under the person centered planning process, though those specific exceptions, clarifications, and implementation questions (from both people receiving services and people providing them) should be addressed during the various waiver stakeholder process. CDCAN will send out information as any new guidance or information regarding the new regulations from the Department of Health Care Services (or other departments) or from the Centers on Medicare and Medicaid Services (CMS) becomes available].

The new federal regulations, which became effective March 17, 2014 specifies that service planning for

participants in Medicaid Home and Community Based Services Waiver program must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The federal regulations require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences.

The federal regulations established new requirements for the qualities of settings that are eligible for reimbursement under the Medicaid Home and Community-Based Services Waivers that require home and community based settings that are based on the experience and outcomes of individuals under person center planning rather than physical or other characteristics of a particular setting.

Specifically, the federal regulations requires that all home and community-based settings must:

- Be integrated in and support full access to the greater community;
- Be selected by the individual from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices; and
- Facilitate choice regarding services and who provides them

The federal regulations also include additional requirements for settings in where the community-based provider funded under a Medicaid Home and Community Services Waiver also owns or operates the residence of the individual who receives services under the waiver. In these settings, an individual who receives services under the waiver must:

- Have a lease or other legally enforceable agreement providing similar protections;
- Have privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- Control his/her own schedule including access to food at any time;
- Be able to have visitors at any time; and
- Have a setting that is physically accessible.

The federal regulations also defines other settings presumed to have institutional qualities that would not be in compliance with the home and community based services setting requirement, including any setting that has the effect, according to the Centers on Medicare and Medicaid Services of "...discouraging integration of individuals...from the broader community of individuals not receiving such services". Should states decide to include any of these other settings in their Medicaid HCBS programs, CMS will exercise "heightened scrutiny," meaning the state must demonstrate, via a process that includes public input, that the setting does not have the qualities of an institution and does have the qualities of a community based setting as defined and allowed in the new regulations. The federal regulations also clarifies that the home and community-based setting requirements apply to non-residential settings where home and community based services are delivered such as day programs and pre-vocational training settings.

While the new federal regulations tightens requirements for the states it also includes changes to make it easier for states to access Medicaid funds for home and community-based care including giving the states the option to combine under a single waiver, coverage for several different populations currently covered under separate waivers.

HOW TO COMMENT ON THE DRAFT STATEWIDE TRANSITION PLAN

FIRST PUBLIC COMMENT PERIOD: The Department of Health Care Services intends to receive and review public comments on the initial draft Statewide Transition Plan from September 19^th through October 19, 2014, with a public stakeholder conference call scheduled for October 21, 2014 (Tuesday) from 10:00 AM to 12:00 noon to presumably to give a brief overview of next steps, answer questions and receive additional comments. The call in number is: 888-829-8671 Participant passcode: 7335142

SECOND PUBLIC COMMENT PERIOD: The Department of Health Care Services indicated that it will then post on its webpage a revised version that will be released by October 27^th, that will reflect changes and revisions including those from public comments received from the first public comment period. Following the posting of the Revised Draft Statewide Transition Plan, the department will receive and review public comments on Revised Draft Statewide Transition Plan from October 27, 2014 through November 26, 2014. That will be followed by a second public stakeholder call scheduled for December 2,

2014 (Tuesday) from 10:00 AM to 12:00 noon. The call in number is: 888-829-8671 Participant passcode: 7335142
WHERE TO SEND COMMENTS: Submit all comments to: STP@dhcs.ca.gov (mailto:STP@dhcs.ca.gov)

LINKS FOR MORE INFORMATION
WEBPAGE OF DEPARTMENT OF HEALTH CARE SERVICES HOME & COMMUNITY BASED SERVICES (HCBS) STATEWIDE TRANSITION PLAN:
http://www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx
DRAFT STATE TRANSITION PLAN (SEPTEMBER 19, 2014) – PDF DOCUMENT COPY (12 PAGES) FROM DEPARTMENT OF HEALTH CARE SERVICES WEBPAGE:
http://www.dhcs.ca.gov/services/ltc/Documents/HCBS_Statewide_Transition_Plan_9-19-14.pdf
WEBPAGE OF CENTERS ON MEDICARE AND MEDICAID SERVICES HOME AND COMMUNITY BASE SERVICES:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-SupportS/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html
ACTUAL FEDERAL REGULATION:
Final Federal Regulations from Federal Register on Medicaid Home and Community Based Services Waiver (January 16, 2014) - PDF Document Copy (93 Pages):
http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf
PRESENTATION, FACT SHEETS, Q&A, INFORMATIONAL BULLETINS FROM CMS:
Presentation (Slides) by Centers on Medicare and Medicaid Services of the new regulations (January 29, 2014) – PDF Document Copy (59 pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Final-Rule-Slides-01292014.pdf
Overview of the Final Rule (Fact Sheet) from Centers on Medicare and Medicaid Services (January 10, 2014) – PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/final-rule-fact-sheet.pdf
Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule (January 10, 2014) - PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/1915c-Fact-Sheet.pdf
Fact Sheet: Summary of Key Provisions of the Final Rule for 1915(i) Home and Community-Based Services (HCBS) State Plan Option (January 10, 2014) - PDF Document Copy (2 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/1915i-fact-sheet.pdf
Summary of Key Provisions of the Home and Community Based Services Settings from the Centers on Medicare and Medicaid Services (January 10, 2014) – PDF Document Copy (4 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/HCBS-setting-fact-sheet.pdf
Informational Bulletin on Final Rule by Centers on Medicare and Medicaid Services (January 10, 2014) - PDF Document Copy (53 Pages):
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-10-14.pdf
Questions and Answers on the Final Rule from Centers on Medicare and Medicaid Services (January 10, 2014) – PDF Document Copy (5 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Final-Q-and-A.pdf
SETTINGS REQUIREMENTS, TOOLKITS & GUIDANCES FROM CMS:
Document Showing Outline of Heightened Scrutiny Process by Centers on Medicare and Medicaid Services (no date) - PDF Document Copy (1 Page):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Heightened-Scrutiny.pdf
Graph of Steps To Compliance For HCBS Settings Requirements In A 1915(C) Waiver And 1915(I) State Plan Amendment (SPA) from Centers on Medicare and Medicaid Services (no date) - PDF Document Copy (1 Page):

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/HCBS-1915c-waiver-compliance-flowchart.pdf
Statewide Transition Plan Toolkit for Alignment with the Home and Community-Based Services (HCBS) Final Regulation's Setting Requirements (September 5, 2014) – from Centers on Medicare and Medicaid Services - PDF Document Copy (7 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Statewide-Transition-Plan-Toolkit-.pdf
Regulatory Requirements for Home and Community-Based Settings of those that comply and those settings that are excluded from Centers on Medicare and Medicaid Services -PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Requirements-for-Home-and-Community-Settings.pdf
Additional Technical Guidance On Regulatory Language Regarding Settings That Isolate from Centers on Medicare and Medicaid Services – PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Settings-that-isolate.pdf
Exploratory Questions to Assist States in Assessment of Residential Settings from Centers on Medicare and Medicaid Services - PDF Document Copy (6 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Exploratory-questions-re-settings-characteristics.pdf

CDCAN - MARTY OMOTO YOUTUBE CHANNEL
A CDCAN (Marty Omoto) youtube channel was set up and has several videos dealing with current – and previous state budget issues, disability and senior rights, and advocacy.
To see the current videos, including March 2014 San Andreas Regional Center Aptos Legislative Breakfast, January 2014 panel discussion on services for adults with autism spectrum and related disorders in Palo Alto, and older videos including video of April 2003 march of over 3,000 people with developmental disabilities, families, providers, regional centers and others from the Sacramento Convention Center to the State Capitol (to attend and testify at budget hearing on proposed massive permanent cuts to regional center funded services, go to the CDCAN (Marty Omoto) Channel at:
https://www.youtube.com/channel/UCEySEyhnr9LQRiCe-F7ELhg
More videos – including new current videos (an interview with longtime advocate Maggie Dee Dowling is planned, among others) – plus archive videos of past events – will be posted soon.

Photo of Marty Omoto, executive director of CDCAN
PLEASE HELP!!!!!!
SEPTEMBER 22, 2014 (Marty Omoto pictured left)
PLEASE HELP CDCAN CONTINUE ITS WORK
CDCAN Townhall Telemeetings, CDCAN Reports and Alerts and other activities cannot continue without YOUR help. To continue the CDCAN website and the CDCAN Reports and Alerts sent out and read by over 65,000 people and organizations, policy makers and media across the State, and to continue and resume CDCAN Townhall Telemeetings, trainings and other events, please send your contribution/donation (please make check payable to "CDCAN" or "California Disability Community Action Network" and mail to:
CDCAN – NEW MAILING ADDRESS:
1500 West El Camino Avenue Suite 499
Sacramento, CA 95833
[replaces 1225 8^th Street Suite 480, Sacramento, CA 95814]
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549 (replaced 916-212-0237)

Many, many thanks to all the organizations and individuals for their continued support that make these reports and other CDCAN efforts possible!

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Our mailing address is:
Marty Omoto - ** martyomoto@rcip.com (mailto:martyomoto@rcip.com)

Tri-Counties Association for the Developmentally Disabled
VENDOR ADVISORY COMMITTEE

CMS FINAL RULE TASK FORCE COMMITTEE AGENDA
Thursday, October 2, 2014 / 9:00AM – 10:00AM

TCRC Annex (Across the street from TCRC at 520 E. Montecito St., SB)
Video conferencing available at the San Luis Obispo and Oxford offices of TCRC
(Call for directions: SLO 543-2833; Oxnard 485-3177)

NEW CONFERENCE NUMBER -
CONFERENCE CALLING NUMBER: 1-877-262-0913 – Conference ID: 5802721#

AGENDA

9:00	Review Statewide Transition Plan (Handout) • Collaborate to identify areas needing clarification
9:20	Review CMS Transition Plan Guidelines (Handout)
9:35	Review Proposed Stakeholder Meeting Details • Dates and Times
9:45	Discussion – Next Steps
9:55	Golden Gate Regional Center Conference on The Impact of CMS Changes
10:00	Adjourn

Golden Gate Regional Center
Transformation Institute: A Tale of Two Organizations

November 20, 2014

10:00 a.m.- 5:00 p.m.

California State Office Building, 1515 Clay Street, Oakland, CA

Self-determination, new state and federal guidelines and legislation, judicial rulings and support from the business community are propelling movement from segregated settings to community based non-work and competitive employment. Participants will be presented with 2 scenarios of actual organizations going through the organizational change process to community. These scenarios will assist participants in increasing their knowledge about the factors that are necessary for successful organizational transformation.

Objectives
Participants will be able to:

1. Explain the provisions in Department of Justice decrees, CMS rulings, and the Workforce Innovation and Opportunities Act that are promoting life in the community.
2. Discuss Kotter's 8 steps for organizational change and describe how these can be applied to IDD organizations going through change.
3. Talk about a realistic funding model that will support a life in the community, including employment.
4. Describe effective communication strategies for individuals, families, Board members and staff to increase their support for the change.
5. Explain competencies and responsibilities of community-based staff.
6. List the essential elements needed for a successful transformation.

Agenda

10:00-10:20	Welcome and Icebreaker
10:20-11:00	The state and federal legislative and regulatory landscape
11:00-11:30	Transformational change steps *Practice*
11:30-11:45	Break
11:45-1:00	Tale of 2 Organizations • Leadership • Values • Communication (internal & external) *Practice*
1:00-1:30	Lunch
1:30-3:00	Tale of 2 Organizations • Work Plan (Discovery, person centered planning, staffing, timelines, facility management, transportation, data collection) • Funding (costing, pricing, leveraging funding sources) *Practice*
3:00-3:15	Break
3:15-4:30	Tale of 2 Organizations • Managing resistance • Building competency • Sharing results *Practice*
4:30-5:00	Conclusions

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: July 7, 2014

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: Clarification of Medicaid Coverage of Services to Children with Autism

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD. [1]

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. [2] While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)[3]. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

[1] http://www.cdc.gov/ncbddd/autism/facts.html
[2] http://www.cdc.gov/ncbddd/autism/treatment.html
[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider's qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state's Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state's Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency"

A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long at the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs; that is, all services that can be covered under section 1905(a), including licensed practitioners' services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to AutismServicesQuestions@cms.hhs.gov.

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont) Behavioral Health Treatment (BHT)	Covered as medically necessary services based upon a written prescription of a licensed physician or psychologist for Applied Behavioral Analysis (ABA) Therapy, to develop or restore, to the maximum extent practicable, the functioning of an individual with a diagnosis of Autism Spectrum Disorder (ASD). Under this state plan only for the following beneficiaries: infants, children and adolescents age 0 to 21, who are an eligible beneficiary of the EPSDT program, that exhibit excesses or deficits of behaviors that significantly interfere with home and community services. Individuals must have a comprehensive diagnostic evaluation that indicates ABA-based therapy services are medically necessary and recognized as therapeutically appropriate.	ABA-based therapy services require prior authorization for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for reimbursement except in the case of retroactive Medi-Cal eligibility. Services must be provided under a treatment plan developed and approved by a "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3), treatment maybe administered by one of the following: 1. A qualified autism service provider. 2. A qualified autism service professional supervised and employed by the qualified autism services provider. 3. A qualified autism service paraprofessional supervised and employed by a qualified autism service provider. ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall: 1. Be person-centered and based upon individualized goals over a specific timeline; 2. Be developed and approved by the qualified autism service provider for the patient being treated; 3. Delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors; 4. Identify long, intermediate, and short-term goals and objectives that are behaviorally defined; 5. Identify the criteria that will be used to measure achievement of behavior objectives; 6. Have objectives that are specific, measurable,

* Prior authorization is not required for emergency service.
* *Coverage is limited to medically necessary services

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont) Behavioral Health Treatment (BHT)		based upon clinical observations, utilize evidence-based practices with demonstrated clinical efficacy, in treating ASD, include outcome measurement assessment, and are tailored to the individual; 7. Ensure that interventions are consistent with ABA techniques; 8. Clearly identify the service type, number of hours, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the individual's progress is reported, and the individual providers responsible for delivering the services; 9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and 10. Include parent/caregiver training, support and participation.

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

DHCS
TOBY DOUGLAS
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

DATE:

All Plan Letter 14-xxx

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: INTERIM POLICY FOR THE PROVISION OF BEHAVIORAL HEALTH TREATMENT (BHT) COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with interim policy guidance for providing BHT services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BACKGROUND:
ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called Autism Spectrum Disorder. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. While much of the current national BHT discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to

Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
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include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and avoiding the assumption that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

The Department of Health Care Services (DHCS) intends to provide BHT services as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health and Safety Code. The DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with stakeholders. The department will further develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for ABA services, subject to the limitations allowed under federal law and provide final policy guidance to Plans as soon as possible.

Pursuant to Section 14132.56 of the Welfare & Institutions Code, DHCS is required to perform the following in development of the benefit:

(1) Obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal.
(2) Seek statutory authority to implement the benefit in Medi-Cal.
(3) Seek an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.
(4) Consult with stakeholders.

In consultation with stakeholders, the department will develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for BHT services, subject to the limitations allowed under federal law. DHCS may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for

the purpose of obtaining subject matter expertise or other technical assistance in implementing this service. Contracts may be statewide or on a more limited geographic basis.

INTERIM POLICY:
In accordance with existing contracts, Medi-Cal MCPs are responsible for the provision of EPSDT services and EPSDT Supplemental Services for Members 0 to 21 years of age, including those who have special health care needs. Plans shall inform members that EPSDT services are available for beneficiaries 0 - 21 years of age, provide comprehensive screening and prevention services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, and lead toxicity screening), and provide treatment for all medically necessary services including but not limited to BHT.

Plans shall cover all medically necessary mandatory and supplemental EPSDT services for beneficiaries 0 to 21 years of age including health education services, vision, dental and hearing services, and various therapies and other long-term services and supports. In addition to ensuring coverage of EPSDT services, Plans shall ensure an adequate level of benefits and services. Plans shall also ensure that appropriate EPSDT services are initiated in a timely fashion - as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Medi-Cal MCPs are responsible for the provision of EPSDT services for beneficiaries 0 to 21 years of age. Effective September 15, 2014, this includes medically necessary ABA services for children or adolescents with ASD that meet eligibility criteria for services.

Future guidance will be issued pertaining to the provision of other BHT services not addressed in this APL.

CONTINUITY OF CARE:
MCP beneficiaries 0 to 21 years diagnosed with ASD who are currently receiving BHT services including ABA services through a Regional Center will continue to receive these services through the Regional Center until such time that the department and the Department of Developmental Services develop a plan for transition. In addition, for Medi-Cal beneficiaries receiving ABA services outside of the MCPs' network for Medi-Cal services, the MCPs shall ensure continuity of care for up to 12 months in accordance with existing contract requirements.

HEALTH PLAN READINESS:
DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCP are timely providing medical necessary ABA services. DHCS and DMHC will engage in a joint decision making process when considering the content of any licensing filing submitted to either Department. The Departments will work together to issue template language to MCPs, as needed.

Guidance pertaining to readiness review requirements will be provided to MCPs separate from this APL.

DELEGATION OVERSIGHT:
MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including APLs.

REIMBURSEMENT:
The department will engage in conversations with the MCPs in order to develop capitation rates for the costs associated with the provision of ABA services. Any rate adjustments will be retroactively applied to September 15, 2014.

To the extent beneficiaries received ABA services from licensed providers between July 7 and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process (http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx). On and after September 15, 2014, beneficiaries must receive ABA services from the MCP unless they are receiving their ABA services from a Regional Center.

PROGRAM DESCRIPTION AND PURPOSE :
BHT means professional services and treatment programs, including but not limited to ABA and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. ABA-based therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence and are not experimental.

RECIPIENT CRITERIA FOR ABA-BASED THERAPY SERVICES:
In order to be eligible for ABA-based therapy services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be 0 to 21 years of age and have a diagnosis of ASD;
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to aggression, self-injury, elopement, etc.);
3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);

4. Have a comprehensive diagnostic evaluation that indicates ABA-based therapy services are medically necessary and recognized as therapeutically appropriate; and
5. Have a prescription for ABA-based therapy services ordered by a licensed physician and surgeon or a licensed psychologist.

COVERED SERVICES AND LIMITATIONS:

Medi-Cal covered ABA-based therapy services must be:

1. Medically necessary as defined by Welfare & Institutions Code Section 14059.5.
2. Prior authorized by the Medi-Cal Program or its designee; and
3. Delivered in accordance with the recipient's treatment plan.

Services must be provided under a treatment plan developed and approved by a "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3), 1374.73(c)(4), and 1374.73(c)(5). Treatment may be administered by one of the following:

1. A qualified autism service provider.
2. A qualified autism service professional supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

ABA-based therapy services must be based upon a treatment plan and prior authorized for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall:

1. Be person-centered and based upon individualized goals over a specific timeline;
2. Be developed and approved by a qualified autism service provider for the patient being treated;
3. Delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors;
4. Identify long, intermediate, and short-term goals and objectives that are behaviorally defined;
5. Identify the criteria that will be used to measure achievement of behavior objectives;
6. Have objectives that are specific, measureable, based upon clinical observations, utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, include outcome measurement assessment, and are tailored to the individual;
7. Ensure that interventions are consistent with ABA techniques.
8. Clearly identify the service type, number of hours, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at

which the individual's progress is reported, and the individual providers responsible for delivering the services;
9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
10. Include parent/caregiver training, support, and participation.

Service Limitations:
1. Services must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. Any services delivered must be under the supervision of a qualified autism service provider.
4. ABA-based therapy services shall be discontinued when the treatment goals and objectives are achieved or are no longer appropriate.

The following services do not meet medical necessity criteria, nor qualify as Medi-Cal covered ABA-based therapy services for reimbursement:
1. Therapy services rendered when measureable functional improvement is not expected or progress has plateaued;
2. Services that are primarily respite, daycare or educational in nature and are not used to reimburse a parent for participating in the treatment program;
3. Services that are duplicative services and equal to the medically necessary frequency and duration under an individualized family service plan (IFSP) or an individualized educational program (IEP), as required under the federal Individuals with Disabilities Education Act (IDEA);
4. Treatment whose purpose is vocationally- or recreationally-based;
5. Custodial care;
   a. for purposes of these provisions, custodial care:
      i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
      ii. is provided primarily for maintaining the recipient's or anyone else's safety; and
      iii. could be provided by persons without professional skills or training.
6. Services, supplies, or procedures performed in a non-conventional setting including, but not limited:
   a. resorts;
   b. spas; and
   d. camps.
7. Services rendered by a parent, legal guardian, or legally responsible person.

For questions about this APL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments

ARCA ASSOCIATION OF REGIONAL CENTER AGENCIES
915 L Street, Suite 1440, Sacramento, California 95814 • 916.446.7961 • Fax: 916.446.6912 • www.arcanet.org

September 25, 2014

Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

RE: Draft State Plan Amendment (SPA) for Applied Behavior Analysis (ABA) as a Covered Medi-Cal benefit for individuals under 21 years of age

To Whom It May Concern:

The Association of Regional Center Agencies (ARCA) represents the state's community-based network of regional centers which serves over 270,000 individuals with developmental disabilities, including approximately 70,000 individuals diagnosed with Autism Spectrum Disorder (ASD). ARCA appreciates the opportunity to comment on the proposed SPA that would add ABA as a Medi-Cal covered benefit for individuals with ASD under the age of twenty-one.

ARCA has the following significant concerns with the draft SPA:

- The draft SPA would only expand current Medi-Cal benefits to include the funding of ABA services for individuals with ASD. As noted in the Center for Medicaid and CHIP Services Bulletin dated July 7, 2014, "there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan[1]." While ABA is a crucial ASD treatment modality, children and families must have access to an array of evidence-based treatments to meet their particular clinical needs. They should not have to wait for California to seek approval of a later SPA application to access these services.

- The proposed eligibility criteria for Medi-Cal funding of BHT that requires "the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities" is more restrictive than the requirement that EPSDT services be available if they are "determined to be medically necessary to correct or ameliorate any physical or behavioral conditions." At times, EPSDT services may also be required to maintain current skill levels. While the All Plan Letter issued on September 15, 2014 provides additional examples of behaviors that might warrant intervention, more inclusive eligibility criteria consistent with EPSDT standards should be applied.

[1] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

Thank you for the opportunity to provide comment. Should you have any questions regarding these suggestions, please don't hesitate to contact Amy Westling in our office at awestling@arcanet.org or (916) 446-7961.

Sincerely,
/s/
Eileen Richey
Executive Director

Cc: Santi Rogers, Director, Department of Developmental Services

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont) Behavioral Health Treatment (BHT)	Covered as medically necessary services based upon a written prescription of a licensed physician or psychologist for Applied Behavioral Analysis (ABA) Therapy, to develop or restore, to the maximum extent practicable, the functioning of an individual with a diagnosis of Autism Spectrum Disorder (ASD). Under this state plan only for the following beneficiaries: infants, children and adolescents age 0 to 21, who are an eligible beneficiary of the EPSDT program, that exhibit excesses or deficits of behaviors that significantly interfere with home and community services. Individuals must have a comprehensive diagnostic evaluation that indicates ABA-based therapy services are medically necessary and recognized as therapeutically appropriate.	ABA-based therapy services require prior authorization for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for reimbursement except in the case of retroactive Medi-Cal eligibility. Services must be provided under a treatment plan developed and approved by a "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3), treatment maybe administered by one of the following: 1. A qualified autism service provider. 2. A qualified autism service professional supervised and employed by the qualified autism services provider. 3. A qualified autism service paraprofessional supervised and employed by a qualified autism service provider. ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall: 1. Be person-centered and based upon individualized goals over a specific timeline; 2. Be developed and approved by the qualified autism service provider for the patient being treated; 3. Delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors; 4. Identify long, intermediate, and short-term goals and objectives that are behaviorally defined; 5. Identify the criteria that will be used to measure achievement of behavior objectives; 6. Have objectives that are specific, measurable,

* Prior authorization is not required for emergency service.
* *Coverage is limited to medically necessary services

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont) Behavioral Health Treatment (BHT)		based upon clinical observations, utilize evidence-based practices with demonstrated clinical efficacy, in treating ASD, include outcome measurement assessment, and are tailored to the individual; 7. Ensure that interventions are consistent with ABA techniques; 8. Clearly identify the service type, number of hours, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the individual's progress is reported, and the individual providers responsible for delivering the services; 9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and 10. Include parent/caregiver training, support and participation.

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services