**CMS informal responses**
**To CA's informal responses to formal RAI**
**CA 1166 SDP waiver**
**9/22/16**
**Updates with comments in red 12/7/16**

CRITICAL RESOLUTION ISSUES

**Appendix B: Participant Access and Eligibility**

1. **B-3-f. Selection of Entrants to the waiver** - Please clarify if all eligible individuals are granted entrance into the waiver or indicate the process for the selection of entrants that is based on objective criteria and applied consistently in all geographic areas served by the waiver.

State's response

No, not all eligible individuals will be granted entrance into the waiver. The Department of Developmental Services (DDS) will use a stratified random selection process for selecting entrants so that all interested individuals will have an equal opportunity to participate. The process will be as follows: First, DDS will receive lists from regional centers of interested individuals who attended a required Pre-Enrollment Informational Meeting at each regional center. Second, DDS will take the lists and randomly select participants for each regional center so selection will be representative of the State for ethnicity, age, gender, and disability diagnosis.

CMS Response: Please update the application with this information.

- In order to first enroll the 150 participants in the pilot program, please reserve capacity for them and outline this in Appendix B-3-c of the waiver application.

**10. Home Health Aide Services** - Specify the additional services that are provided when the state plan benefit is exhausted. Please also specify the state plan service limit.

State's response

Home Health Aide Services under the state plan are limited to the amount that is determined medically necessary, which varies for each individual. If the planning team determines that the individual could benefit, as documented in the individual program plan (IPP), from services in addition to those provided under the state plan, these additional services may be purchased through the SDP Waiver.

CMS Response: Please amend language to read the services would be determined based on assessed need opposed to if the individual could "benefit" from the service.

**11. Respite** - The state's service definition includes "regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver(s) are out of the home." Please clarify as to how this service will include activities that are beyond the scope of child care, and how this service is necessary to avoid institutionalization. Additionally, the state needs to specify the limits on these services since respite is a temporary service.

State's response

As noted in the definition, respite services may only be provided when the care and supervision needs of the individual exceed those of a person of the same age without developmental disabilities. Therefore, these services exceed the scope of day/child care services. The provision of respite services provides temporary relief from the on-going care and supervision needs of an individual. Without these respite periods for the family/caregivers, out-of-home residential options may be necessary. The State will amend the wavier application to indicate that out-of-home respite may not exceed 30 consecutive days.

CMS Response: The state does not have to establish a cost limit, as long as waiver costs do not exceed aggregate institutional costs. The state will have to provide assurance in the definition/service specifications and further specify in the rate methodology in Appendix I-2-a how the state will only pay for care that goes beyond the scope of child care. The waiver cannot be used to pay for child care. The state must fully establish that this is a respite service for the purpose of relieving the caregiver on a temporary basis. If the state wishes to establish this as a service delivered on a regularly scheduled basis, this would no longer be considered temporary and therefore, would be subject to the settings requirements.

**13. Communication Support** - Please indicate how this is service is different than technology services and specialized medical equipment and supplies and how duplicate billing will not occur.

State's response
California's application for Appendix C-3: Waiver Services will be revised to state that communication support services will be limited to personnel who will assist participants with limited English proficiency skills, or impairments in hearing, speech, and/or vision to effectively communicate with service providers, family, friend, co-workers, and the general public. Technology services include purchasing/leasing equipment or products that enable the participants to have independence in accessing the community. Technology services may also include training on specific devices. Specialized medical equipment and supplies are durable and non-durable medical equipment or devices that enable participants to manage activities of daily living that are not available under the state plan.

CMS Response: Please clarify the equipment is not already covered under DME under the mandatory home health benefit in the state plan.

**22. Individual Training and Education** - How will the state ensure this service is not duplicative of other waiver services? For example, employment related training appears duplicative of the employment supports waiver service. In addition, community integration, advocacy, and community living supports all have similar components.

State's response
The individual training and education service is specific to participation and/or attendance at trainings, conferences, forums, etc. and the purchase of related materials needed to participate in these conferences. This is different than the on-going support provided within the employment supports waiver service or other wavier services which consist of ongoing on the job training.

CMS Response: It is not permissible for the state to include a waiver service to cover the cost of conferences and/or training materials for conferences. Only participant-specific training that is

necessary for the individual participant to avoid institutionalization can be included under a 1915(c) waiver.

**28. Specialized Therapeutic Services** - Please remove this service from the waiver. This service is not available through a 1915(c) waiver.

State's response
Specialized Therapeutic Services is an approved service in California 1915(c) Waiver CA.0336.R03.00 and was an approved service in the prior version. We request clarification as to why the service must be removed from the SDP Waiver.

CMS Response: The state cannot use the waiver to pay a provider more for a service they are being reimbursed for under a state plan service. Medicaid requires providers to accept Medicaid payment as payment in full. The waiver can be used to pay for extended state plan service, but this is to extend the amount, duration or scope of a service under the state plan. Please redefine the waiver service to reflect the state plan limits and what is being extended.

**38. C-5: Home and Community-Based Settings**

a. Please include a list of the specific settings where individuals will reside.
b. Please include a list of specific settings where individuals will receive services.
c. Please include a detailed description of the process the state Medicaid agency used to assess and determine that all waiver settings meet the HCB settings requirements.
d. Please include the process that the state Medicaid agency will use to ensure all settings will continue to meet the HCB settings requirements in the future.

State's response

a. SDP participants may reside in a privately owned, leased or rented home or apartment by themselves, with their family or with roommates of their choosing. These settings are presumed to be in compliance with the HCB settings requirements. Additionally, participants may reside in licensed community care facilities, adult family homes or foster family homes that meet the HCB settings requirements.
b. In addition to receiving services where they reside, as identified above, participants may also receive services in a multitude of places including in general community locations (e.g. employment setting, office of a health practitioner, etc.); in settings that may or may not be designed to predominantly provide services to people with developmental disabilities and that are subject to licensure (e.g. community care facilities, adult or child day care.)
b. For each setting selected by a participant, an assessment will be completed to determine if it comports with the HCB settings requirements. The assessment is organized to first ask questions that are representative of highly integrated settings. For example, settings that do not limit provision of service to, or are not designed specifically for, people with disabilities; and settings presumed to be home and community-based such as non-provider-owned or controlled private residential homes. Because these settings are compliant or presumed to be compliant with the settings rules, the remainder of the assessment would not need to be completed.

   Next, the assessment includes questions about settings that are not options for participants because they are not home and community-based (hospitals, nursing facilities, institution for

mental diseases, or intermediate care facilities for individuals with intellectual/development disabilities) or they are presumed not to be home and community-based (located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, in a building on the grounds of, or immediately adjacent to, a public institution, or that has the effect of isolating individuals from the broader community). Settings that are institutional or are "presumed institutional" based on CMS regulations and guidance, will not be options for SDP participants. The participant will receive guidance on selecting other locations to receive services.

The remaining questions in the assessment pertain to provider controlled licensed/certified/congregate settings. The assessment questions are based on CMS guidance and documentation of how the setting meets each of the requirements is required. Participants may only receive services in those settings that fully meet all requirements, as certified by the regional center and FMS provider.

c. The IPP planning team and FMS provider will annually review the assessment to verify on-going compliance with the HCB settings requirements. On-going compliance will also be monitored as part of the State's biennial monitoring reviews.

CMS Response:

a. The following settings can be found throughout the waiver application that are not accounted for here. They are also indicated in your response to E-1-c. Please include all settings within this waiver that must comport with HCBS regulations regarding the final rule including the following: Adult Residential Facility, Adult Residential Facility for Persons with Special health Care Needs, Certified Family Home, Group Home; Small Family Home, Residential Care Facility for the Elderly, Family Teaching Homes
b. Please clarify there are no non-residential settings in this waiver where services are received.
c. Assessments would need to be completed in full on all settings regardless of a few preliminary questions. If someone is already doing an assessment of the location it would be advisable to do a complete assessment to assure the settings comports.
    - Please include each of the requirements the settings must meet.
    - Please further explain the assessment process from beginning to completion.
    - Who is completing the assessment?
    - How is the assessment validated by the state initially?
    - What is the process for the assessment timeline? At what point in the process is the assessment completed?
    - All settings must meet the requirements of the final rule; the additional conditions apply to provider owned and controlled settings. The state may make the presumption that privately owned or rented homes and apartments of people living with family members, friends, or roommates meet the HCBS settings requirements if they are integrated in typical community neighborhoods where people who do not receive HCBS also reside. A state will generally not be required to verify this presumption. However, as with all

settings, if the setting in question meets any of the scenarios in which there is a presumption of being institutional in nature and the state determines that presumption is overcome, the state should submit to CMS necessary information for CMS to conduct a heightened scrutiny review to determine if the setting overcomes that presumption. In the context of private residences, this is most likely to involve a determination of whether a setting is isolating to individuals receiving HCBS (for example, a setting purchased by a group of families solely for their family members with disabilities using HCBS services). Please clarify that the states presumption of compliance encompasses all of the requirements for HCB settings as required under 441.301(c)(4)(i-v).

d. Please be specific regarding how the planning team will access ongoing compliance and how ongoing compliance will be worked into the current biennial monitoring?
    - Will the ongoing monitoring process include the assessment of individuals own homes to ensure that the states presumption that it meets the requirements of the rule is accurate? If the monitoring is not completed by the same entities who are completing the biennial monitoring for provider owned and controlled settings, who is doing the monitoring and are they trained to assess for the characteristics of HCBS. Please outline this process to ensure that the ongoing monitoring includes monitoring of non-provider owned or controlled settings.
    - Please clarify what "annually review the assessment" means. Does this mean a settings assessment will be completed annually?

**49. E-1-i-i: Payment for FMS** - Please specify how the state will compensate the entities that provide FMS services. Per the HCBS Waiver Technical Guide examples could be a per transaction fee, a monthly fee per participant, a combination of both types of fees,or another method. The state indicates in response to this item in the waiver that FMS costs will be paid from the individual budget but that the individual budget will not be increased to include these costs. This is not permissible. The state may include the FMS waiver service costs in an individual budget but then must reflect and account for this is the individual budget methodology as described in Appendix E-2-b-ii.

State's response

The FMS will be reimbursed a monthly, per participant fee. The cost for this service is considered as the participant determines the appropriate service mix and costs within each budget category.

CMS Response:

- What is the formula for the cost and how is it applied consistently?
- Does the state intend to include FMS services to a person's budget or is the state still intending on cutting an individual's budget to accommodate the FMS cost as well as the independent facilitator cost?
- If a cut occurs how will the state assure that that there will not be a negative impact on those whose budgets were cut and how there will not be a loss of services.

- How are budgets determined for those who had not utilized the other 1915(c) waiver and there is not a 12 month data to use for them.
- Please note it is not permissible for FMS payment to be adjusted as proposed.