



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



GAVIN NEWSOM
GOVERNOR

December 28, 2022

THIS LETTER SENT VIA EMAIL

Ms. Michele Mackenzie, Technical Director
Division of Long-Term Services & Supports
Disabled & Elderly Health Programs Group
Center for Medicaid & CHIP Services
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HOME AND COMMUNITY-BASED SERVICES (HCBS) SETTINGS FINAL RULE

Dear Ms. Mackenzie:

The State of California (the State) is committed to completing a successful implementation of the Home and Community-Based Services (HCBS) Settings Final Rule and is providing the following information to the Centers for Medicare and Medicaid Services (CMS) to document State and provider compliance with the regulatory criteria. The information below includes a summary of the State's oversight systems that have been modified to embed the Final Rule regulatory criteria, how the State assesses providers for initial compliance and conducts ongoing monitoring, and a description of beneficiaries' recourse to notify the State of provider non-compliance.

Oversight Systems Systemic Assessment

To determine the extent to which State statute, regulations, and policies governing residential and non-residential HCBS settings were in alignment with the HCBS Settings Final Rule, the State conducted a systemic assessment and identified necessary changes. The State solicited stakeholder input on the systemic assessment to ascertain if there were any other needed changes. Where State standards were silent or partially compliant, the State made modifications and/or developed remediation strategies to bring the State into compliance with the federal regulatory criteria.

Assisted Living Waiver (ALW) / Home and Community-Based Alternatives (HCBA) Waiver:

The following updates were made to align program requirements with HCBS Settings Final Rule requirements:

- **Waiver Updates:** The Department of Health Care Services (DHCS) updated the ALW and HCBA Waiver to include an assurance that the waivers are subject to any provisions or requirements included in the State's most recent and/or approved HCBS Settings Statewide Transition Plan.
- **HCBS Provider Attestation:** DHCS created an HCBS Setting Characteristics Provider Attestation document for HCBS applicants and providers to complete to reinforce the requirements of the HCBS Setting final rule.
- **ALW Individual Support Plan (ISP):** DHCS updated the ALW ISP to improve person-centered practices during the development of the care plan to comply with the federal Person-Centered Planning regulations.
- **HCBS Settings Audit Tool:** DHCS updated the existing audit tool used to assess residential settings for compliance with HCBS setting requirements by including questions about residents' access and experience including those related to food, privacy, transportation, visitors.

Developmental Disabilities (DD) 1915(c) Waivers and 1915(i) HCBS State Plan Option for DD:

The following were updated to align program requirements with HCBS Settings Final Rule requirements:

- **Statute:** The Department of Developmental Services (DDS) added a statute authorizing the issuance of policy directives to implement Section 441.530(a)(1) of Title 42 of the Code of Federal Regulations.
- **Waiver/State Plan Updates:** DDS included performance measures in the DD Waiver renewal application and 1915(i) State Plan to monitor the HCBS federal requirements going forward.

Community-Based Adult Services (CBAS):

The following were updated to align program requirements with HCBS Settings Final Rule requirements:

- **Provider Manual:** The California Department of Aging (CDA) included a section related to CBAS into the Medi-Cal Provider Manual which addressed federal HCBS Settings Final Rule requirements for non-residential settings on June 30, 2018.
- **Statute:** The State revised the ADHC/CBAS statutes to include the HCBS Settings Final Rule requirements for non-residential settings on December 31, 2021.
- **Individual Plan of Care (IPC):** The planning process and the development and review of the IPC will comply with the requirements of 42 CFR 441.301(c)(1) through (3), including specifying 1) How the IPC will identify each enrollee's

preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will certify that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

- **Biennial CBAS provider certification renewal process:** CDA has incorporated the following elements into the biennial CBAS provider certification renewal process:
 1. Provider Self-Assessment Tool to be submitted to CDA at time of application for certification renewal and Participant Setting Assessment Tool to be administered to CBAS participants by CDA survey staff in a face-to-face interview during the onsite survey;
 2. A process for reviewing the Provider Self-Assessment Tool during the in house "desk review";
 3. Validation processes for the Provider Self-Assessment Tool incorporated into the onsite certification survey instrument currently used, including participant interviews observations, and review of specific health and administrative records; and
 4. Review and validation processes for the Participant Setting Assessments obtained during the onsite survey.

Oversight and Monitoring: Initial and Ongoing

ALW / HCBA:

Initial Compliance

DHCS's initial program application process includes a comprehensive review of not only the applicant's policies and procedures, compliance with waiver requirements, and provider readiness, but also applicants' compliance with federal and statutory waiver requirements, including those related to the HCBS Settings Final Rule, such as freedom of choice, employment support, protection of individuals' rights to privacy and dignity, and full access to the community.

In addition, DHCS conducts initial on-site assessments to validate providers' compliance with all federal regulations, including the HCBS Setting Final Rule, to confirm Medicaid enrollment requirements are met prior to approval. Going forward, as part of the initial program/enrollment processes, DHCS will continue to verify new providers comply with all federal, state, and regulatory requirements and criteria, including HCBS Settings Final Rule requirements, to maintain CMS compliance.

The State validated compliance with the HCBS Final Rule by contracting with Public Consulting Group (PCG) to conduct the on-site assessments of all settings in 2019. DHCS completed the 100% on-site assessment of three hundred and one (301) settings. All 301 providers were found to be out of compliance and were required to complete a Remediation Work Plan (RWP). DHCS reviewed and validated 100% of RWPs.

An assessment tool was developed from CMS exploratory questions and was used for the on-site assessment of each setting, to determine the current level of compliance with the Final Rule. On-site assessments took place during normal operating hours. Facility staff was interviewed about daily activities and living. Photographs were taken as evidence. On-site assessments included but were not limited to a review of:

- Documented observation of the setting for compliance with standards
- Individuals' person-centered plans of care
- Provider policies, procedures, transportation information, and handbooks
- Staff training schedules
- Lease agreement templates, participant rights documents
- Assessment of building, and location, including accessibility for individuals

Ongoing Monitoring

DHCS monitors HCBS settings' compliance with the HCBS Settings Final Rule by utilizing current ongoing licensing and/or certification processes for both residential and non-residential settings. Existing program monitoring tools have been modified to embed the regulatory criteria to assess providers' compliance of HCBS settings. Criteria to assess Final Rule compliance have been included in tools utilized for facility on-site visits, beneficiary interviews, and clinical file review tools. The program monitoring tools are used to verify that providers are allowing residents to have free access to the community, protecting individual's rights to privacy, and ensuring participant freedom of choice. DHCS program monitoring staff receive on-going training on updates to the program monitoring tool and Final Rule requirements. DHCS conducts audits annually using a random sampling of facilities. Any provider found to be noncompliant with Final Rule requirements will be placed on enrollment restriction and placed on a corrective action plan (CAP) to resolve deficiencies.

DHCS conducts QA on-site reviews of the Residential Care Facilities for the Elderly (RCFE), Adult Residential Facilities (ARFs), Home Health Agencies (HHA) in the Public Subsidized Housing (PSH) setting, and Care Coordination Agencies (CCA) providing ALW services. DHCS will inform providers of any deficiencies that are identified in a letter of non-compliance outlining the deficiencies found at the facility. The provider will respond to the letter of non-compliance by completing the CAP template provided by DHCS identifying corrective actions they will take to remediate deficiencies outlined by DHCS. DHCS will work with provider to address deficiencies. DHCS' monitoring process consists of activities that include, but are not limited to the review of participant case files and face-to-face interviews with individuals receiving services.

DHCS monitors the health and welfare of HCBA Waiver participants. Monitoring activities include provider qualification screening, home visits, HCBA Waiver service utilization reviews, data collection, and onsite compliance program monitoring reviews. The data systems used for these activities include Medi-Cal's Case Management Information System (CMIS); Service, Utilization, Review, Guidance & Evaluation (SURGE) system; Event/Issue Reports; and the California Medicaid Management Information System (CA-MMIS). The tools and resources used to gather compliance data include but are not limited to:

- Quality Management Case Record Review Tool
- Menu of Health Services (MOHS)
- Provider Visit Reports

DD Waiver and 1915(i) State Plan:

Initial Compliance and Ongoing Monitoring

DDS' initial compliance determination process includes a comprehensive review of the provider's policies and procedures, working with the provider to remediate areas of non-compliance, and validation that policies and procedures reflect all elements of the HCBS federal requirements, as noted in the Statewide Transition Plan.

DDS will use existing processes to monitor ongoing compliance. DDS is revising its monitoring protocols to include a review of all elements of the HCBS settings requirements. Included in these revisions will be a focus on obtaining information from individuals served about their experiences, in addition to on-site observations, provider and staff interviews, and documentation reviews. DDS is also working with licensing entities to identify potential updates to monitoring activities/protocols to align with the HCBS settings requirements.

CBAS:

Initial Compliance and Ongoing Monitoring

To determine initial and ongoing levels of compliance, remediate non-compliance, and maintain full and continuous compliance, the CDA is using existing oversight and monitoring mechanisms required by state law. By state law, all CBAS providers must reapply for continuing participation in the Medi-Cal program at least once every two years. This certification renewal process begins with an application (e.g., standardized disclosure forms, provider agreements, and various other program documents) and includes a desk review of requested documents, an onsite survey of the center to determine compliance with CBAS program requirements, and statements of deficiency and corrective action plans as indicated. CDA survey staff conduct the onsite monitoring and oversight processes at CBAS centers. With input from stakeholders, CDA added the following to the CBAS provider certification renewal process to create a robust, ongoing oversight and monitoring process to determine compliance with HCB Settings regulations:

1. Provider Self-Assessment Tool to be completed and submitted to CDA by all CBAS providers at the time of the CBAS provider's application for certification renewal;
2. Process for review of the Provider Self-Assessment Tool by the CDA survey team during the in-house "desk review" prior to the CDA onsite survey visit;
3. Participant Setting Assessment Tool to be used by CDA survey staff in a face-to-face interview with CBAS participants during the onsite survey and evaluated as part of the survey validation process; and
4. Validation processes for HCB Settings compliance incorporated into the onsite survey instrument and process currently used by CDA survey staff, including participant interviews, CBAS center staff interviews, observations, and review of specific health and administrative records.

All review and validation processes by the CDA survey teams for Participant Setting Assessments occur during the onsite certification survey. There are no follow-up processes to validate participant surveys after CDA's onsite survey. Note: CDA's monitoring responsibilities and activities are ongoing throughout a center's two-year certification period. Settings found to be out of compliance with the new regulations during these routine reviews will be required to submit and have approved a corrective action plan which includes a timeframe for its completion. Centers generally implement corrections within 60 days of submission of their corrective action plans. Failure to complete a plan of correction may jeopardize the provider's certification and participation in the CBAS program. Providers rarely fail to regain compliance during the corrective action process. Nonetheless, CDA has CBAS center closure procedures which CBAS centers must follow if a CBAS center closes, requiring the transitioning of CBAS participants out of the center. Center closure procedures can be found on the CDA website. These closure procedures would apply to CBAS centers that are unable to come into compliance with the HCB Settings requirements by March 17, 2023, and thereafter as determined during the CBAS center certification renewal process every two years.

Beneficiary Recourse of Provider Non-Compliance

The State provides supports to beneficiaries residing in or participating in the following programs through the Office of the Long-Term Care Ombudsman:

- Adult Day Programs
- Adult Day Health Care Facilities
- Residential Care Facilities for the Elderly (Includes CCRCs)
- Adult Residential Facilities
- Congregate Living Health Facilities

Beneficiaries may reach out to the LTC Ombudsman via their local area Ombudsman or the 24/7 CRISIS line. All residential HCBS settings are required to post, in a visible location, the phone number for the local Ombudsman office and the Statewide CRISIS line number. Once notified of a suspected non-compliance, the Ombudsman's office will

notify the appropriate state agency overseeing that program for additional follow up and action.

ALW / HCBA:

DHCS has a “no-wrong door” policy for any beneficiary, their designee or family members, employees, or provider to report any allegations of wrongdoing by a provider. Complaints and concerns may be reported via email, phone call, the long-term care ombudsman, through the supervising CCA or Waiver Agency (WA), and DHCS has multiple email boxes that participants may utilize to report a concern/complaint.

HCBA and ALW beneficiaries are contacted monthly by their WA or CCA respectively. During these monthly visits, beneficiaries may report any provider non-compliance to their case manager. Case managers are required to notify DHCS of any observed or reported non-compliance. CCAs and WAs are also required to inform residents of their rights and whom to notify if a rights violation occurs. Before the transition deadline, DHCS will provide guidance, training, and checklists to both WAs and CCAs regarding participant rights guaranteed by the final rule and how to inform the state of provider noncompliance. DHCS conducts regular monthly one-on-ones with WA and bi-monthly meetings with CCAs to discuss any concerns or issues they may be having, provide technical assistance, and reinforce expectations.

Once DHCS receives notification of suspected non-compliance, DHCS conducts a review of the complaint to identify what are the issues and the appropriate next steps by talking with the complainant. DHCS may establish a compliance conference with the provider and conduct a desk audit of applicable documents or, if a complaint requires, conduct an on-site audit of the facility to investigate these claims. In the event a provider is determined to be non-compliant, a CAP will be issued to the provider. Failure to address the deficiencies identified in the CAP will result in disenrollment of the provider from the ALW or HCBA Waiver.

DD Waiver and 1915(i) State Plan:

Individuals receiving services through Regional Centers, or any representative acting on behalf of any individual(s) receiving Regional Center services, may pursue a complaint to the Director of the Regional Center. If unsatisfied with the Regional Center’s response, the complaint may be filed with the Director of the DDS. The Director, within 45 days of receiving a complaint, will issue a written administrative decision and send a copy of the decision to the complainant, the Director of the Regional Center, and the service provider, if applicable. Individuals receiving services may also utilize the State’s fair hearing process, which is a process for resolving disagreements between the Regional Center and the individual. Under the fair hearing process, disagreements may be about specific services, eligibility, or any decision or action of the Regional Center with which the individual disagrees. The fair hearing process includes a voluntary informal meeting, mediation, and/or a fair hearing. In addition to the existing grievance procedures for individuals receiving services, the DDS Ombudsperson is a resource for any individuals who receive services.

CBAS:

Processes currently in place for CBAS participants, their family/caregivers, and/or their authorized representatives to file appeals and grievances offer strong protections and support compliance with the HCBS Settings Regulations.

Medi-Cal beneficiaries have the right to file an appeal and/or grievance under State law when they receive a written notice of action regarding a loss of benefits or a denial or reduction of CBAS services. Additionally, Medi-Cal managed care members may file a grievance with their managed care plans at any time that they experience dissatisfaction with the services or quality of care provided to them. Existing CBAS regulations afford participants the right to file grievances at their CBAS centers to address problems they identify in the delivery of their care at the CBAS center and in the center's compliance with HCBS Settings Final Rule requirements.

CBAS providers are required to inform participants, their family/caregivers, and authorized agents about their grievance rights and protections as part of the [CBAS Participation Agreement](#) they must sign before they begin receiving services at a CBAS center. *(Relevant Excerpt: "Discussed my rights with me, including my right to discuss my concerns about the care I receive at the center. If needed, I understand I can request help with resolving my concerns through the center's grievance procedure.")*

These rights and protections ([Participant Rights](#)) are to be posted for public view in a conspicuous place at the CBAS center in the predominant languages spoken by center participants.

During CDA's biannual on-site Medi-Cal recertification surveys of all CBAS centers, CDA's survey team enhances existing processes for monitoring CBAS centers to determine if CBAS participants, their family/caregivers, and authorized representatives have been informed about and received a copy of participants' grievance rights and protections, that policies and procedures for filing grievances/complaints are in place, and that grievances and subsequent actions taken are documented and available for review by the State.

CDA's certification survey teams review a center's grievance/complaint log and the actions the CBAS provider took to resolve the complaint. Based on the complaint and actions taken described in the log, CDA will determine if additional action is needed including interviewing whoever filed the grievance or complaint to determine if their complaint was resolved satisfactorily. Based on this investigation, CDA would determine if a deficiency citation is warranted requiring an approved Plan of Correction for the center to be recertified. In addition, the State must guarantee that there are no retaliatory actions toward anyone filing a grievance/complaint or appeal.

Related, during a CBAS center's recertification survey, a sample of CBAS participants are interviewed to determine their satisfaction with the services they are receiving at the center, with the staff who are providing the services, and other issues relevant to determining a CBAS center's compliance with the federal HCB Settings requirements. The [CBAS Transition Plan](#) describes this process including how the CDA survey team reconciles differences between CBAS provider's and participants' responses. All CBAS

centers must comply with the federal HCB Settings requirements to be certified/recertified to participate in the Medi-Cal program.

If a CBAS participant, his/her family/caregiver, and/or authorized representative are not satisfied with the outcome of the above described complaint/grievance processes or may not be aware of these processes, they may contact CDA's CBAS Program directly about a complaint/grievance via phone (916-419-7545) or CBAS Mailbox (cbascda@aging.ca.gov). CDA investigates all complaints which could include (with the complainant's consent) contacting the CBAS provider about the complaint, requesting center documents, and speaking with staff relevant to the complaint, as well as contacting the participant's managed care plan.

CDA will guarantee that for anyone contacting the CBAS Bureau with a complaint or concern about a CBAS provider and/or provision of CBAS services, the complaint is addressed, and the complainant is provided information to assist in the resolution of the complaint.

If you have any questions about California's Statewide Transition Plan or the updates included in this letter, please contact Ms. Cortney Maslyn, Division Chief, Integrated Systems of Care Division, at (279) 599-2822, or by email at Cortney.Maslyn@dhcs.ca.gov.

Sincerely,

A handwritten signature in blue ink that reads "Jacey Cooper". The signature is fluid and cursive, with the first and last names being clearly legible.

Jacey Cooper
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cc: See Next Page

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