

Special Terms and Conditions of Approval

CENTERS FOR MEDICARE AND MEDICAID SERVICES

NUMBER: (11-W-00184/9)

TITLE: California In-Home Supportive Services Plus

AWARDEE: California Department of Health Services

The following are Special Terms and Conditions for the award of the California In-Home Supportive Services Plus §1115 Demonstration program. The Special Terms and Conditions are arranged in eight subject areas: General Program Requirements, General Reporting Requirements, Legislation, Assurances, Operational Protocol, and Attachments regarding General Financial Requirements, Monitoring Budget Neutrality for the Demonstration, Summary Schedule of Reporting Items, Evaluation Framework, and section 1115 Quarterly Report Instructions.

Letters, documents, reports, or other materials that are submitted for review or approval must be sent to the Centers for Medicare & Medicaid Services (CMS) Central Office Demonstration Project Officer and the State representative in the CMS Regional Office.

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I. GENERAL PROGRAM REQUIREMENTS

1. **Extension or Phase-out Plan.** The State will discuss demonstration extension plans with the Centers for Medicare & Medicaid Services (CMS) at least 18 months prior to demonstration expiration, and requests for extensions are due to CMS no later than 12 months prior to the expiration of the demonstration. If the State does not request an extension, it must submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 12 months prior to the expiration of the demonstration. The phase-out plan must be submitted to CMS to review and consider for approval.
2. **CMS' Right to Suspend or Preclude the Demonstration Implementation.** CMS may suspend or preclude Federal financial participation (FFP) for State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.
3. **State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.
4. **CMS' Right to Terminate or Suspend the Demonstration Operation.** During demonstration operation, CMS may suspend or terminate FFP for any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with any of the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination. The effective date of such action shall not be fewer than 45 days from the date of notice. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. The CMS reserves the right to withhold waivers and authority for pending FFP for costs not otherwise matchable or to withdraw waivers or authority for costs not otherwise matchable at any time if it determines, after good faith consultation with the State, that granting or continuing the waivers or authority for costs not otherwise matchable would no longer be in the public interest. If the waiver or authority for costs not otherwise matchable is withdrawn, CMS will be liable only for normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.
5. **Cooperation with Federal Evaluators.** The State will fully cooperate with Federal evaluators and their contractor's efforts to conduct an independent Federally funded evaluation of the demonstration program.

II. GENERAL REPORTING REQUIREMENTS

(Attachment C provides a summary of the frequency of required reporting items.)

6. **Monthly Progress Calls.** Before and for 6 months after implementation, CMS and the State will hold monthly calls to discuss demonstration progress. After 6 months of operation, CMS and the State will determine appropriate frequency of progress calls.
7. **Quarterly & Annual Progress Reports.** The State will submit quarterly progress reports that are due 60 days after the end of each quarter in accordance with Attachment E. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. CMS reserves the right to request the annual report in draft. The reports will address, at a minimum:
 - A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
 - A discussion of the State's progress in completing eligibility determinations outlined in the Eligibility Determination Plan, and completing steps outlined in the Quality Assurance and Quality Improvement Plan;
 - Notable accomplishments, including findings from Quality Assurance and Quality Improvement, participant survey, and evaluation activities; and
 - Problems/issues that were identified and how they were solved.
8. **Final Demonstration and Evaluation Report.** At the end of the demonstration period, a draft final report will be submitted to CMS for comments. CMS' comments shall be taken into consideration by the State for incorporation into the final report. The final report with CMS' comments is due no later than 180 days after the termination of the project.

III. LEGISLATION

9. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in Federal laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

If the law, regulation, or policy statement cannot be linked specifically with program components that are, or are not, affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

10. **Changes in Federal Law Affecting Medicaid.** The State will, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 Demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

If the new law cannot be linked specifically with program components that are, or are not, affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without-waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

11. **Amending the Demonstration.** The State may submit an amendment for CMS, consideration requesting exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration program do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

IV. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance that the following will be met:

12. **Assurances Included in Application:** All assurances checked in the State's application by this reference are included as items in these Special Terms and Conditions of Approval, and will be fulfilled as part of the Special Terms and Conditions of Approval.
13. **Preparation and Approval of Operational Protocol.** The State will prepare an Operational Protocol Document, which represents all policies and operating procedures applicable to this demonstration, and will submit the Operational Protocol to CMS for approval. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval.
Requirements and required contents of the Operational Protocol are outlined in Section V of these Special Terms and Conditions.
14. **Medi-Cal Eligibility.** All individuals served under the IHSS Plus demonstration will be determined Medi-Cal eligible by qualified Medi-Cal eligibility workers using Medi-Cal eligibility rules. This will include adherence to Medi-Cal rules for determining spend-down and share of cost. The State will conduct redeterminations of these IHSS Plus participants between July 1, 2004, and October 1, 2005, to ensure they are Medi-Cal eligible. Beginning August 1, 2004, all new applicants for personal care services under the demonstration will be determined Medi-Cal eligible using Medi-Cal rules. Supplemental Security Income procedures for determination of presumptive disability will be followed.
15. **Ineligible Individuals - Unqualified Aliens.** Federal financial participation (FFP) is not available for prohibited aliens. The State assures that any Federal financial payments received for participants who are unqualified aliens or those subject to the 5-year bar will be returned to CMS.
16. **Federal Financial Participation Availability.** FFP is only available after the first year of the demonstration for persons found (or determined to be) Medi-Cal eligible through the redetermination process. Redeterminations are to be conducted for each recipient no less than once per year.
17. **Source of Funds.** All State and local sources of funds (non-Federal share) for IHSS Plus must comply with Federal requirements, including the criteria for certified public expenditures (CPE) as described in Federal regulations at 42 CFR 433.51 (and DHS maintenance of documentation for the CPE) and intergovernmental transfers as described in section 1903(w)(6)(A) of the Act.
18. **Voluntary.** The program is voluntary for all demonstration participants.

19. **Services.** The State will cover under its State plan the Protective Supervision and Domestic and Related services described in the original waiver request
20. **Self-Directed Supports.** The State will provide adequate resources to support participants in securing and managing their personal care service providers and hours, including but not limited to:
 - a. A person-centered planning process is used to identify participants' long-term care needs and the resources available to meet these needs, and to provide access to additional care options, including the choice to use spouse and parent caregivers, and to access a prospective monthly cash payment under the Advance Pay option;
 - b. A fiscal agent/intermediary is available to all participants;
 - c. Access to a provider registry and assistance in locating a provider;
 - d. An assurance of the right to hire, fire, and supervise the work of their providers pursuant to State law;
 - e. Social worker/case managers are available to participants to conduct assessments and annual reassessments, inform participants of their rights and responsibilities, monitor the quality of each participant's personal care services, assist participants with learning their roles and responsibilities as "employer" and to understand the roles and responsibilities of their providers, act as points of contact if participants have questions or their care providers are unavailable, oversee the funds provided to participants through either an allocation of hours of service or through the Advance Pay option, ensure that service allocations and services provided are consistent with the assessment and care plan, and make referrals to other community resources when participants' care needs exceed the scope of services or hours permitted under the demonstration program; and
 - f. An independent advocate or advocacy system is available to all participants in the demonstration program which includes the Protection and Advocacy System, the State and Local Long-Term Care Ombudsman Programs, the Department of Mental Health, the Department of Developmental Services, the Office of Civil Rights in the DSS and the DHS, the Area Offices for Aging, the Adult Protective Services system and Regional Centers.
21. **Quality Assurance and Quality Improvement Plan (QA/QI).** The State Department of Health Services (DHS) will design and implement an overall QA/QI Plan that effectively assures the health and welfare of program participants. The QA/QI Plan will be phased-in according to a timeline and will be fully implemented no later than July 1, 2005. The DHS QA/QI Plan will, at a minimum, include the following:
 - a. Each county, with assistance from the State Department of Social Services (DSS), will develop a QA/QI plan for discovery, remediation, and improvement and submit it for approval to the DHS no later than January 1, 2005;
 - b. The DSS Adult Programs Branch Evaluation and Integrity Unit will develop a protocol for reviews, periodic home visits and data collection; and
 - c. The DHS will monitor implementation of the QA/QI county plans and DSS oversight of the county QA/QI activities. DHS monitoring activities will include, but are not limited

to, reviewing county reports and corrective action plans, and auditing the county QA/QI systems and plans.

22. **Adequacy of Infrastructure.** This demonstration will provide adequate resources to support participants in directing their own care. The support assures, but is not limited to, participants' compliance with laws pertaining to employer responsibilities, provision for back-up attendants as needs arise, and the performance of background checks on employees and guidance to participants on the results of checks. Adequate resources for implementation, monitoring activities, and compliance to the terms and conditions of approval of the demonstration will be provided by the State.
23. **Assistance of a Proxy.** This demonstration is designed to assist individuals who are capable of directing their own care. Individuals not capable of directing their own care will not be deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative), will not be excluded from program participation.
24. **Supplant Services.** Cash payments provided under this demonstration program do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.
25. **Notification to Program Participants.** Participants of the IHSS RP will be informed of the changes to the IHSS RP under IHSS Plus, including, but not limited to, their enrollment into a section 1115 research and demonstration program, and adherence to Medi-Cal eligibility as well as share of cost provisions which could result in possible eligibility changes at the time of redetermination and a recalculation of their financial responsibilities.
26. **Enrollment of New IHSS Plus Participants.** Participants in PCSP, as they are reassessed, and individuals newly assessed to need personal care services, will be informed and counseled on the self-directed personal care assistance and service options available under the demonstration program.
27. **Evaluation.** The State will conduct an evaluation of the program and will cooperate with an independent evaluation contractor CMS may procure.
28. **Public Notice Requirements.** The demonstration complies with public notice requirements as published in the *Federal Register*, Vol. 59, No. 186 dated September 29, 1994 (Document number 94-23960), and CMS requirements regarding Native American Tribe consultation.

V. OPERATIONAL PROTOCOL

29. **Operational Protocol Timelines and Requirements.** The Operational Protocol will be submitted to CMS no later than 30 days after program approval. CMS will respond within 30 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the terms and conditions of approval, those issues being necessary to approve the Operational Protocol.

Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

30. Required Contents of Operational Protocol:

- a. **Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform.
- b. **Reporting Items.** A description of the content and frequency of each of the reporting items as listed in Section II and Attachments A and C of this document.
- c. **Benefits.** Descriptions or listings of:
 - procedures for determining the plan of care;
 - procedures for reviewing plans of care and making adjustments to payments;
 - procedures governing the Advance Pay options; and
 - the county modes of operation (Public Authorities, Non-Profit Consortia, Joint Powers Agencies, County as Employer), along with their responsibilities, and the service delivery modes (Individual Provider Mode, Contract Mode and Homemaker Mode).
- d. **Notice/Outreach/Marketing/Education.** A description of the State's notice, outreach, marketing, education, and staff training strategy. *NOTE: All marketing materials must be reviewed and approved by CMS prior to use.* Include in the description:
 - the plan for DSS review and revision of county and DSS IHSS RP materials and brochures to incorporate changes necessitated by the demonstration program. The DSS review and revision of these materials will be completed by July 1, 2005;
 - the contents of the transition notice that will be sent to IHSS RP recipients to announce the implementation of the IHSS Plus demonstration program and their transition to the demonstration program, including, but not limited to, the effective date of their transition, a toll-free number to the State DSS if they have questions about the IHSS Plus demonstration program or the notice, and a description of remedies if there is any change in their assessed IHSS hours or services.

- staff training schedules, schedules for State forums or seminars to educate the public; and
 - the availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost-sharing responsibilities.
- e. **Eligibility/Enrollment.** A description of the population of individuals eligible for the demonstration (and eligibility exclusions) and population phase-in and the following:
- the plan by which the State will conduct eligibility redeterminations of IHSS Plus participants to ensure they are Medi-Cal eligible;
 - the plan by which the State will conduct initial eligibility determinations of all new applicants for personal care services under the demonstration;
 - annual redeterminations for financial eligibility and reassessments of the need for personal care services;
 - intake, enrollment, and disenrollment procedures;
 - procedures for determining the existence and scope of a demonstration applicant's existing third-party liability; and
 - the State agency that will be responsible for each of the above processes.
- f. **Quality Assurance and Quality Improvement Plan.** Description of an overall Quality Assurance and Quality Improvement plan, consistent with Special Term and Condition #20 in Section IV of the Assurances, that includes, but is not limited to the following:
- the mechanisms the State will utilize to ensure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately;
 - the system the State and the counties will operate by which they timely receive, review and act upon critical events or incidents, with a description of the critical events or incidents;
 - social worker/case management staff responsible for monitoring participant health and welfare;
 - quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;
 - plans to report survey results, service utilization, and general quality assurance findings to CMS as part of the quarterly and annual reports;
 - procedures for ensuring quality of care and participant safeguards;
 - procedures for insuring against duplication of payment between the demonstration, and fee- for-service and Home and Community-Based Services programs; and,
 - fraud control provisions and monitoring.
- g. **Support Services - Education, Counseling, Fiscal/Employer Agent.** Descriptions of the following topics will be included:
- the State's and counties' relationships and arrangements with organizations providing enrollment/assessment, counseling, training, and fiscal/employer agent services;

- the Case Management Information and Payroll System (CMIPS), including the roles and
 - responsibilities of the State Controllers Office and CMIPS vendor; and
 - procedures for the provision of training opportunities for participants of the demonstration who require assistance with managing care providers and reporting hours of care.
- h. **Support Services - Participant Protections.** A description of the State procedures and processes to ensure that protections are in place. The description will include the following:
- procedures to ensure that participants have the requisite information and/or tools to direct and manage their care, including, but not limited to, training in managing their caregivers, assistance in locating caregivers, as well as completing and submitting paperwork associated with billing, payment, and taxation;
 - a plan and timeline by which the State will incorporate into the assessment and care planning process, an assessment of the critical services that, if unavailable, would likely place each participant at risk of harm, including the failure of the participant's care provider to show up, and the development of an individualized contingency plan to manage assessed risks;
 - a plan and timeline by which the State will make available a system-wide contingency plan in the event the participant's individualized contingency plan fails;
 - procedures for how the State will recoup overpayments, including how additional supports will be provided to participants to ensure appropriate expenditure of funds, and that services needed to avoid out-of-home placement and the continuation of the health and welfare of the individual are available; and
 - the process by which the State makes available to participants, at no cost, provider qualification/background checks, including a description of how participants may access criminal background checks conducted by the State Department of Justice and/or the investigations of qualifications and backgrounds of potential providers maintained at the county level or in the provider registries.
- i. **Evaluation Plan and Design.** A description of the State's evaluation plan and design. The description will include the following: (Attachment D provides an Evaluation Framework)
- discussion of the demonstration hypotheses that will be tested;
 - outcome measures that will be included to evaluate the impact of the demonstration on participant satisfaction and average costs for Medicaid services as compared to those persons being served under the State plan PCSP;
 - what data will be utilized;
 - methods of data collection;
 - effects of the demonstration will be isolated from those other initiatives occurring in the State;
 - any other information pertinent to the State's evaluative or formative research via the demonstration operations; and
 - plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of participant satisfaction and costs for Medicaid services).

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The Centers for Medicare & Medicaid Services (CMS) will provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).
2.
 - a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System, following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.
 - b. For each demonstration year, a Form CMS-64.9 WAIVER and/or 64.9P WAIVER will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.).
 - c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include Medicaid expenditures on behalf of demonstration participants (as described in number 3.c. and d. of this section) that also are receiving the services subject to the budget neutrality cap. The services subject to budget neutrality include demonstration services and the following categories as they appear on the CMS-64 WAIVER forms: Personal Care Services, Durable Medical Equipment, and Home Health Agency services.

- 4.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap, as defined in 2c. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State for the quarter, and will include the reconciling adjustment in the finalization of the grant award to the State.
- 5.** The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

 - a.** Administrative costs, including those associated with the administration of the demonstration.
 - b.** Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
 - c.** Net medical assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration.
- 6.** The State will certify State/local monies used as matching funds for the CA IHSS+ Initiative and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B

MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

The following describes the method by which budget neutrality will be ensured under the demonstration. The demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing Federal financial participation (FFP) for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS ensures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an overall expenditure limit for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the Federal Medical Assistance Percentage rate(s) applicable to that year.

Projecting Service Expenditures

Each DY budget estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. The DY 1 will begin on August 1, 2004. The trended amounts by DY are the following:

<u>Year</u>	<u>Parent Spouse</u>	<u>Advanced Pay</u>	<u>Protective Supervision – Parent/Spouse Providers</u>
01	\$ 825	\$ 2,127	\$ 2,282
02	\$ 885	\$ 2,282	\$ 2,449
03	\$ 949	\$ 2,448	\$ 2,627
04	\$ 1,018	\$ 2,626	\$ 2,818
05	\$ 1,092	\$ 2,818	\$ 3,023

<u>Year</u>	<u>Domestic and Related – Parent/Spouse Providers or Meal Allowance</u>	<u>Multiple Services</u>
01	\$ 300	\$ 1,944
02	\$ 322	\$ 2,086
03	\$ 346	\$ 2,237
04	\$ 371	\$ 2,400
05	\$ 398	\$ 2,575

Refinement to Existing Trended Monthly Per Person Cost

By January 31, 2005, the State will review the data from which the monthly per person costs were calculated and submit any necessary refinements to the calculations that address the following:

- the removal of what will become State plan PCS expenditures from the Protective Supervision, Domestic and Related and Multiple Services components, and other impacted services for non-demonstration participants;
- the Domestic and Related component (expenditures and member months) must be broken-out into two separate components: 1) domestic services, and 2) meal allowances;
- all demonstration and impacted services must be retained for demonstration participants; and
- Otherwise merited corrections or inaccuracies in the preliminary data.

Revising the Trended Monthly Per Person Cost

In demonstration programs where participation is voluntary and the participation rate represents a minority percentage of the population eligible to participate, a revision to the trended monthly per person cost in specified demonstration year(s) may be considered by the State and CMS when the State implements provider fee increases that: 1) are irregular in nature; 2) materially exceed the agreed upon trend rate in the year the fee is implemented; and 3) are implemented through the State plan and affect the cost of those services included in the demonstration budget neutrality cap on a statewide basis.

The intent of this provision is to protect the State from system-wide fee increases that are: 1) pending at time of award but could not be reasonably assessed prior to award or undefined at the time of award; 2) are not included in the historical State experience used in determining the agreed upon budget neutrality cap; and 3) are not specifically targeted to the demonstration population.

The State, when requesting revision to the MPPC, must provide the following information to CMS on: 1) the full budget effect of the fee increase, including the amount and implementation dates of the current and past fee increases for all services in the MPPC; 2) the MPPC disaggregated by major service categories and number of services for each category,

demonstrating the effect with, and without, the new rate increase; and 3) the current assessment and projections of with, and without, waiver costs.

Impermissible Disproportionate Share Hospital, Taxes or Donations

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, healthcare-related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any healthcare-related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and healthcare-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

How the Limit will be Applied

The limit calculated above will apply to actual expenditures for demonstration and impacted services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, it must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

<u>Year</u>	<u>Cumulative target definition</u>	<u>Percentage</u>
Year 1	Year 1 budget estimate plus	8 percent
Year 2	Years 1 and 2 combined budget estimate plus	3 percent
Year 3	Years 1 through 3 combined budget estimate plus	1 percent
Year 4	Years 1 through 4 combined budget estimate plus	0.5 percent
Year 5	Years 1 through 5 combined budget estimate plus	0 percent

ATTACHMENT C

SUMMARY SCHEDULE OF REPORTING ITEMS

Item	Timeframe for Item	Frequency of Item
Monthly Conference Calls	Prior to demonstration implementation and Post-implementation.	Monthly progress calls with CMS and the State.
Operational Protocol	Due to CMS 30 days after program approval, CMS comments 30 days after receipt, and State completion/CMS approval thereafter.	One Operational Protocol. Changes to the Operational Protocol must be submitted and approved by CMS.
Quarterly/Annual Progress Reports	Due to CMS 60 days after the end of a quarter.	One quarterly report per Federal fiscal year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report.
Final Report	Due to CMS 180 days after the end of the demonstration.	One final report.

ATTACHMENT D

EVALUATION FRAMEWORK

Section 1115 demonstrations are valued for information on health services, health services delivery, healthcare delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS encourages states with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations—states, Federal Government, and individuals—benefit from state-conducted self-evaluations that include process and case-study evaluations. These would include, but not be limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QIs) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status and/or quality of life. Studies such as these contribute to state and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should states have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
 - Use of experts through technical contracts or advisory bodies;
 - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
 - Selection of existing indicators or development of innovative indicators;
 - Types of studies to be included, such as Process Evaluations, Case-Studies, and Outcome investigations;
 - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or participant purchases of other sources of healthcare coverage; and whether the data collection instruments will be existing or newly developed tools;

- Incorporation of results through QA/QI activities into improving health service delivery; and,
- Plans for implementation and consideration of ongoing refinement to the evaluation plan.
- Study Questions – Discuss:
 - Hypothesis or research questions to be investigated;
 - Goals, such as:
 - Increase Access
 - Cost-Effectiveness
 - Improve Care Coordination
 - Increase Family Satisfaction and Stability
 - Outcome Measures, Indicators, and Data Sources
- Control Group and/or Sample Selection Discussion:
 - The type of research design(s) to be included -
 - Pre/Post Methodology
 - Quasi-Experimental
 - Experimental
 - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used
- Data Collection Methods – Discuss the use of data sources such as:
 - Enrollment and outreach records;
 - Medicaid claims data;
 - Vital statistics data;
 - Provide record reviews;
 - School record reviews; and
 - Existing or custom surveys
- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
 - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
 - How findings will be incorporated into outreach, enrollment, and education activities;
 - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
 - How findings will be incorporated into grievance and appeal proceedings.
- Discuss additional points as merited by interest of the State and/or relevance to nuances of the demonstration intervention.

ATTACHMENT E

SECTION 1115 QUARTERLY REPORT INSTRUCTIONS

As written in Special Term and Condition #7, California is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

This report shell is intended as a framework and can be modified when agreed upon by CMS (CO and RO) and the State. A complete report also will include a budget neutrality monitoring table.

California IHSS Plus Demonstration
Section 1115 Demonstration Quarterly Report

Demonstration/Quarter Reporting Period:

Example: 1/1/04 – 3/31/04 – Demonstration Year 1, Quarter 1

Introduction:

A brief description of the goal of the demonstration, its intent, and dates of approval/operation. This should basically be the same for each report.

Enrollment Information:

Please complete the following table that outlines all enrollment activity under the demonstration during the reporting period. The State should indicate “not applicable” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by a “0”. Report unduplicated counts by participant months (can be duplicated across months to include total member months).

DEMONSTRATION PARTICIPANTS	Enrollment Cap	Current Enrollees			No. Voluntary Disenrolled in Current Quarter			No. Involuntary Disenrolled in Current Quarter			No. On Waiting List		
		1	2	3	1	2	3	1	2	3	1	2	3
Monthly Intervals													
Example -	N/A	20	20	20	0	0	2	0	0	0	0	0	0
Example -	N/A	5	5	5	0	0	0	0	0	5	0	0	0
Total		25	25	25	0	0	2	0	0	5	0	0	0

Voluntary Disenrollments:

Cumulative Voluntary Disenrollments to Date:

Reasons for Involuntary Disenrollments:

Involuntary Disenrollments:

Cumulative Involuntary Disenrollments to Date:

Reasons for Involuntary Disenrollments:

Outreach Activities:

Outreach activities in current quarter and any expected for next quarter.

Operational/Policy Issues:

Identify any issues/problems that have occurred, including steps taken to resolve, and the resolution.

Consumer Complaints/Grievances/Appeals to State:

A summary of the types of complaints et al, any trends identified, resolution of complaints et al, and any actions to be taken to prevent other occurrences - if applicable.

Quality Assurance/Monitoring/Evaluation Activity:

Identify any quality assurance/monitoring/evaluation activity in current quarter and any expected for next quarter.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of the document contents.

State Contact(s):

Identify by name, phone, fax, address individuals CMS may contact should any questions arise.

Date Submitted to CMS: Example – March 31, 2003