CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

October 2, 2023

*THIS LETTER SENT VIA EMAIL*

Mr. James G. Scott, Director
Division of Program Operations
Medicaid and CHIP Operations Group
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 0300
Kansas City, MO 64106-2898

STATE PLAN AMENDMENT 23-0036: MINIMUM WAGE AND PROVISIONAL ELIGIBILITY

Dear Mr. Scott:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 23-0036 for your review and approval. DHCS seeks an effective date of January 1, 2024, for this SPA.

This SPA proposes to add the following:

- Modify the definition of target population to include children under 5.
- Increase rates for independent living programs, adult residential homes and participant directed Day Service and Supported Employment.
- Add participant-directed goods and services as a new service.
- Add budget authority for participant direction of services.
- Add additional incentive payments for assisting individuals to obtain competitive integrated employment.
- Add supplemental payments for: completion of surveys for eligible providers of community living arrangement services and direct service providers as workforce capacity initiatives, certifications gained in trained employment services, and for direct service professionals who use a language or medium of communication other than English more than 50% of their time.

In addition, CMS approved the Tribal no-notice on August 25, 2023. DHCS released a public notice on September 1, 2023.

The following documents are included in this submission:

- CMS 179 Form
- Fiscal Impact Summary
- Public Notice

- Standard Funding Questions
- Amended State Plan Pages

If you have any questions or need additional information, please contact Cortney Maslyn, Division Chief of Integrated Systems of Care Division, at (279) 599-2822 or by email at Cortney.Maslyn@dhcs.ca.gov.

Sincerely,

[redacted]

Jacey Cooper
State Medicaid Director
Chief Deputy Director
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Enclosures

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# 1915(i) State Plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State Plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

**1. Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Habilitation- Community Living Arrangement Services; Habilitation- Day Services; Habilitation-Behavioral Intervention Services; Respite Care; Enhanced Habilitation- Supported Employment - Individual; Enhanced Habilitation- Prevocational Services; Homemaker Services; Home Health Aide Services; Community Based Adult Services; Personal Emergency Response Systems; Vehicle Modification and Adaptation; Speech, Hearing and Language Services; Dental Services; Optometric/Optician Services; Prescription Lenses and Frames; Psychology Services; Chore Services; Communication Aides; Environmental Accessibility Adaptations; Non-Medical Transportation; Nutritional Consultation; Skilled Nursing; Specialized Medical Equipment and Supplies; Transition/Set-Up Expenses; Community-Based Training Services; Financial Management Services; Family Support Services; Housing Access Services; Occupational Therapy; Self-Directed Supports Service; Technology Services; Physical Therapy; Intensive Transition Services; Family/Consumer Training; and Participant-Directed Goods and Services.

**2. Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

| | |
|---|---|
| ◉ | **Not applicable** |
| | **Applicable** |
| | Check the applicable authority or authorities: |
| ☐ | **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State Plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*<br>*(a) the MCOs and/or health plans that furnish services under the provisions of§1915(a)(1);*<br>*(b) the geographic areas served by these plans;*<br>*(c) the specific 1915(i) State Plan HCBS furnished by these plans;*<br>*(d) how payments are made to the health plans; and*<br>*(e) whether the 1915(a) contract has been submitted or previously approved.* |
| | |
| ☐ | **Waiver(s) authorized under §1915(b) of the Act.**<br>*Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* |

The individual meets the following need-based criteria:

- Requires assistance with at least three of the following areas of major life activity, as appropriate to the person's age:
  - Receptive and expressive language;
  - Learning;
  - Self-care;
  - Mobility;
  - Self-direction;
  - Capacity for independent living
- Without habilitation services, as defined in Section 1915(c)(5) of the Social Security Act(42 U.S.C. § 1396 et seq.), requires assistance with learning new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands; and
- Demonstrates a likelihood of retaining new skills acquired through habilitation overtime;

Additionally, children zero (0) to four (4) years of age with a disability that is not solely physical in nature and includes significant functional limitations in at least two of the above listed areas of major life activity (does not apply to capacity for independent living, or economic sufficiency given the age of the person), as determined by the regional center are also provisionally eligible for services.

6.☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State Plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

| State Plan HCBS needs-based eligibility criteria | NF (& NF LOC** waivers) | ICF/IID (& ICF/IID LOC waivers) | Applicable Hospital* (& Hospital LOC waivers) |
|---|---|---|---|
| The individual meets the following need-based criteria:<br>• Requires assistance with at least three of the following areas of major life activity, as appropriate to the person's age: | Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's order. The need must | The individual must be diagnosed with a developmental disability and a qualifying developmental deficit exists in either the self-help or social-emotional area. | The individual requires:<br>• Continuous availability of facilities, services, equipment and medical and nursing personnel for prevention, diagnosis or |

| | | | |
|---|---|---|---|
| • Receptive and expressive language;<br>• Learning;<br>• Self-care;<br>• Mobility;<br>o Self-direction<br>o Capacity for independent living | be for a level of service which includes the continuous availability of procedures such as, but not limited to, the following:<br>• Nursing assessment of the individuals' condition and skilled intervention when indicated: | For self-help, a qualifying developmental deficit is represented by two moderate or severe skill task impairments in eating, toileting, bladder control or dressing skill. | treatment of acute illness or injury. |
| 1. Without habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 *et seq.*), requires assistance with learning new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands; and | • Administration of injections and intravenous of subcutaneous infusions;<br>• Gastric tube or gastronomy feedings;<br>• Nasopharyngeal aspiration;<br>• Insertion or replacement of catheters<br>• Application of dressings involving prescribed medications; | For the social-emotional area, a qualifying developmental deficit is presented by two moderate or severe impairments from a combination of the following: social behavior, aggression, self-injurious behavior, smearing, destruction of property, running or wandering away or emotional outbursts. | |

| | | | |
|---|---|---|---|
| 2. Demonstrates a likelihood of retaining new skills acquired through habilitation over<br>Children zero (0) to four (4) years of age with a disability (not solely physical in nature) that includes significant functional limitations in at least two of the above listed areas of major life activity, as determined by the regional center are provisionally eligible for services. | • Treatment of extensive decubiti;<br>• Administration of medical gases | | |

development and takes into account the individual's needs and preferences. Person-centered planning is an approach to determining, planning for, and working toward the preferred future of the individual and her or his family. Decisions regarding the individual's goals, services and supports included in the IPP are made by agreement of the planning team.

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

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

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

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

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

For those participants who receive respite, skilled nursing, non-medical transportation, participant-directed goods and services, and/or community-based training services identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. As required by Title 17, CCR section 58886, when the decision to self-direct services is made, the consumer/family member is provided with information regarding their responsibilities and functions as either an employer or co-employer, as well as the requirement to use and assist in identifying a Financial Management Services provider.

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

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

The regional center case manager assists the recipient in gaining access to needed services and other resources and making informed choice of services and providers according to individual needs and preferences. As a part of the development of the Individual Program Plan (IPP), the case manager informs the recipient and/or his or her legal representative of qualified providers of services in their area determined necessary through the IPP planning process. Recipients may

The above-described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17).

The reimbursement for Supported Employment (Individual Services), (except for services provided to individuals working through an internship), includes incentive payments for measurable milestones identified below:

1. A one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2. An additional one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3. An additional one-time payment made to a provider when an individual has been employed consecutively for one year.
4. After a provider assists four individuals to achieve competitive integrated employment (CIE) placement, an additional payment is made to provider for each consumer thereafter who obtains CIE and is still employed:
    a. after 30 consecutive days.
    b. after six months.
5. For each individual who exits an internship, incentive payments will be paid to service providers when an individual achieves competitive integrated employment and is still employed:
    a. after 30 consecutive days.
    b. after six months.

The reimbursement for Supported Employment (Individual Services) provided to individuals working through an internship includes the following incentive payments:

1. A one-time payment made to a provider when and individual obtains employment through an internship and is still employed after 30 consecutive days.
2. An additional one-time payment when an individual remains in an internship for 60 consecutive days.

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

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State Plan service questions related to sufficiency of services.
(Choose each that applies):

| | |
|---|---|
| ☐ | Categorically needy *(specify limits):* |
| | |

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

Service Title: Financial Management Services

Service Definition (Scope)*:*

Financial Management Services (FMS) are designed to serve as a fiscal intermediary that performs financial transactions (paying for goods and services and/or processing payroll for adult consumers' or their families' workers included in the IPP) on behalf of the consumer. FMS is an important safeguard because it ensures that consumers are in compliance with Federal and state tax, labor, and workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents. All FMS services shall:

1. Assist the family member or adult consumer in verifying worker citizenship status.
2. Collect and process worker timesheets.
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
4. Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
5. Maintain all source documentation related to the authorized service(s) and expenditures.
6. Maintain a separate accounting for each participant's participant-directed funds.
7. Process and pay invoices for goods and services approved in the service plan.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

*(Choose each that applies):*

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| Financial Management Services Provider | | | |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Participant-Directed Goods and Services | | | | | | | |
| Category 1: | | | Sub-Category 1: | | | | |
| | | | | | | | |
| Category 2: | | | Sub-Category 2: | | | | |
| | | | | | | | |
| Category 3: | | | Sub-Category 3: | | | | |
| | | | | | | | |
| Category 4: | | | Sub-Category 4: | | | | |
| | | | | | | | |
| Service Definition (Scope): | | | | | | | |
| Participant-Directed Goods and Services are services and activities that improve and maintain the participant's opportunities for full inclusion in the community, and enable the development of social skills, independence, and personal relationships. Eligible services or activities must promote active participation in the community, address an identified need in the service plan, be documented in the participant's Individual Program Plan, and purchased from the participant's Individual Budget. | | | | | | | |
| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | | | |
| | | | | | | | |
| **Service Delivery Method** *(check each that applies)*: | ☑ | Participant-directed as specified in Appendix E | | ☐ | Provider managed | | |
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative | ☐ | Legal Guardian | |
| Provider Specifications | | | | | | | |
| Provider Category(s) *(check one or both)*: | ☑ | Individual. List types: | ☑ | Agency. List the types of agencies: | | | |
| | Individual provider of goods and services | | Business entity provider of goods and services | | | | |
| | | | | | | | |
| | | | | | | | |

| **Provider Qualifications** | | | |
|---|---|---|---|
| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
| **Individual** | As appropriate, a business license as required by the local jurisdiction where the business is located | N/A | As appropriate and/or required by law for provision of the good or service being provided. |

| | | | |
|---|---|---|---|
| **Business Entity** | As appropriate a business license as required by the local jurisdiction where the business is located | N/A | As appropriate and/or required by law for provision of the good or service being provided. |
| | | | |
| Verification of Provider Qualifications | | | |
| Provider Type | Entity Responsible for Verification | | Frequency of Verification |
| **Individual provider of goods and services** | FMS will verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable. | | Upon selection and prior to service provision. Annually thereafter through the IPP process. |
| **Business entity provider of goods and services** | FMS will verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable. | | Upon selection and prior to service provision. Annually thereafter through the IPP process. |

# Participant-Direction of Services

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

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

| | |
|---|---|
| ○ | The state does not offer opportunity for participant-direction of State Plan HCBS. |
| ○ | Every participant in State Plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services. |
| ◉ | Participants in State Plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):* |
| | Participants who receive respite, financial management services, community-based training services, family support services, Supported employment individual and Habilitation day services, Participant-directed goods and services, skilled nursing or non-medical transportation have the opportunity to direct those services. |

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

In support of personal control over supports and services, self-direction is an option that enables participants to procure their own services. Self-direction of services empowers participants and families by giving them direct control over how and when the services are provided. As an alternative to only receiving services from regional center vendors, families and consumers will have decision-making authority and the freedom to directly control who provides their services and how they are provided.

For those participants who receive Enhanced Habilitation supported employment- Individual Services, habilitation day service, participant-directed goods and services, respite, financial management services, family support services, skilled nursing, non-medical transportation, and/or community-based training services identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. As required by Title 17, CCR section 58886, when the decision to self-direct services is made, the regional center is required to provide the consumer/family member with information regarding their responsibilities and functions, as either an employer or co-employer.

For those selecting to self-direct the indicated services, a Financial Management Service (FMS) provider, vendored by the regional center, will perform selected administrative functions such as payroll, taxes, unemployment insurance, etc. This relieves the participant of the burden of these administrative functions while still having the freedom to exercise decision making authority over

Additionally, Self-Directed Support Services are available to provide guidance and advisement in ensuring a thorough understanding of responsibilities involved with self-direction of services. The purpose is to set consumers up for success in directing their services.

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| | directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*: |
| | |

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

| Participant-Directed Service | Employer Authority | Budget Authority |
|---|---|---|
| Respite | ☒ | ☐ |
| Community-Based Training Services | ☒ | ☐ |
| Skilled Nursing | ☒ | ☐ |
| Non-Medical Transportation | ☒ | ☐ |
| Family Support Services | ☒ | ☐ |
| Financial Management Services | ☒ | ☐ |
| Enhanced Habilitation - Supported employment – Individual Services | ☒ | ☐ |
| Habilitation – Day Service | ☒ | ☐ |
| Participant-directed goods and Services | ☐ | ☒ |

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

| | |
|---|---|
| ○ | Financial Management is not furnished. Standard Medicaid payment mechanisms are used. |
| ◉ | Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State Plan. |

**5.** ☒ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State Plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

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

Participants may choose to switch to non-participant-directed services at any time. A planning team meeting is held to update the IPP, and the case manager facilitates the transition and assures no break in service.

Participant direction of services may be involuntarily terminated when the regional center determines the individual's health and safety is not being supported or when the delivery of services cannot be verified. When there is a disagreement with the change in service delivery, the individual is provided with a Notice of Proposed Action and notified of their Fair Hearing rights. Regardless of the reason for termination of participant-direction, a planning team meeting is held to update the individual program plan and facilitate the transition from participant-direction to prevent a break in services.

**7. Opportunities for Participant-Direction**

***a.*** **Participant–Employer Authority** (individual can select, manage, and dismiss State Plan HCBS providers). (*Select one):*

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

***b.*** **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

| | |
|---|---|
| ○ | The state does not offer opportunity for participants to direct a budget. |
| ◉ | Participants may elect Participant–Budget Authority. |
| | **Participant-Directed Budget.** *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):* |
| | The amount of the individual budget is based on the estimated amounts that are authorized in the service plan for Participant-Directed Goods and Services. The authorized amount is determined by |

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| | the IPP team, through a person-centered planning process and demonstrated assessed need. The budget amount is documented in the IPP and signed by all members of the planning team. The participant receives a copy of the completed document. This amount can be adjusted, up or down, if the IPP team determines that the participant's needs, circumstances, or resources has changed. As described in Appendix F, participants are afforded the opportunity to request a fair hearing when the participant's request for a budget adjustment is denied or the amount of the budget is reduced. This process is applied to each participant who has elected to receive Participant-Directed Goods and Services. |
| | **Expenditure Safeguards.** *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.* |
| | The FMS provides the participant and the regional center service coordinator with a monthly individual budget statement that describes the amount of funds allocated to participant directed goods and services, the amount spent in the previous 30-day period and the amount of funding that remains available under the participant's individual budget. These budget statements can be used to help identify potential issues that may require a review or modification to either the individual budget or individual program plan. |

# DESCRIPTION OF RATE METHODOLOGIES

The following rate methodologies are utilized by multiple providers of the services contained in this SPA. The methodologies are described in this section and are referenced under the applicable individual services. Consistent with Attachment 3.1-i, pages 2-3, qualified providers of 1915i SPA services submit claims to the regional center for services delivered to the beneficiary, pursuant to the individual program plan. The regional center reviews the claim (units of service, rate, etc.), pays legitimate claims, and submits the claim of payment to Department of Developmental Services.

**Department of Developmental Services 2019 Rate Study**

In March 2019, pursuant to Welfare and Institutions Code Section 4519.8, the Department of Developmental Services (DDS) submitted a rate study addressing the sustainability, quality, and transparency of community-based services for individuals with developmental disabilities to the California Legislature. The rate study included an assessment of the effectiveness of the methods used to pay each category of community service provider and included stakeholder meetings and surveys of the provider and recipient community. As a part of the study, rate models were developed for specified services that include specific assumptions related to the various costs associated with delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); California minimum wage, staffing ratios; mileage; facility expenses; and agency program support and administration. Separate models were established for each regional center to account for costs differences related to wages, travel, and nonresidential real estate.

The California Budget Acts of 2021 and 2022 (SB154) provided funding to begin implementation of the rate models as described in the 2019 Rate Study:

- The first stage, effective April 1, 2022, includes an increase equal to 25 percent of the difference between a provider's rate that was effective on March 31, 2022, and the rate models that would apply to their service. This was previously approved.
- The second stage, effective January 1, 2023, will include an increase equal to 50 percent of the difference between a provider's rate that was effective on March 31, 2022, and the rate models that would apply to their service. For example, if a provider has a rate on 3/31/2022 of $40 per hour and the rate identified in the rate model of this service is $44 per hour, the provider's rate will be increased to $42 (the $2 increase being equal to 50 percent of the $4 difference between the current rate and the applicable rate model).

No reductions will occur for provider rates already above the rate recommended by the rate study.

Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation an apportioning those expenses to the Medicaid program, except as expressly modified below.

New homes:
For new homes in which the facility-specific first-year costs are not available, the state will use an estimated average of costs based on similar homes as the estimate for the interim rate. After the first year of operation, the same reconciliation process is followed as described above.

**B. Supported Living Services provided in a Consumer's own Home (Non-Licensed/Certified)** Supported Living Services providers are in this subcategory. Maximum hourly rates for these providers are determined using the median rate methodology, as described on pages 71a-73 above.

**REIMBURSEMENT METHODOLOGY FOR HABILITATION – DAY SERVICES**

This service is comprised of the following three subcomponents:

**A. Community-Based Day Services** – There are three rate setting methodologies for providers in this subcategory.

**1) Rates Set pursuant to a Cost Statement Methodology** – As described on pages 70a-71a, above. This methodology is applicable to the following providers (unit of service in parentheses): Activity Center (daily), Adult Development Center (daily), Behavior Management Program (daily), Independent Living Program (hourly), and Social Recreation Program (hourly). Regional center specific rates in effect as of April 1, 2022 are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study- implementation/rates-by-regional-center/

**2) Median Rate Methodology** – As described on pages 71a-73, above. This methodology is used to determine the applicable daily rate for Creative Art Program, Community Integration Training Program and Community Activities Support Services providers. This methodology is also used to determine the applicable hourly rate for Adaptive Skills Trainer, Socialization Training Program, Personal Assistance and Independent Living Specialist providers, with the exception that the 2022 Rate Study Implementation increase does not apply to Creative Art Program and Socialization Training Program.

**3) Individual Providers (Participant-Directed) –**

a) Personal Assistance – $20.72 per hour, effective January 1, 2024.
b) Independent Living Services– $21.67 per hour, effective January 1, 2024.

**B. Therapeutic/Activity-Based Day Services** – The providers in this subcategory are Specialized Recreation Therapy, Special Olympics, Sports Club, Art Therapist, Dance Therapist, Music Therapist and Recreational Therapist. The units of service for all providers are daily, with the exception of Sports Club providers, who have a monthly rate. There are two rate setting methodologies for providers in this subcategory.

There are five rate setting methodologies for Respite Services. The applicable methodology is based on whether the service is provided by an agency, individual provider or facility, type of facility, and service design.

**1) Rates Set pursuant to a Cost Statement Methodology –** As described on pages 70a-71a, above. This methodology is used to determine the hourly rate for In-home Respite Agencies.

**2) Rates set in State Regulation –** This rate applies to individual respite providers. The rate for this service is based on the current California minimum wage, plus a differential (retention incentive), mandated employer costs, and the SB 81 increase.

Chapter 28, Statutes of 2019 (SB 81, Committee on Budget and Fiscal Review), authorized funding for rate increases. Rates in effect as of October 1, 2021, for Individual Respite Providers includes an increase of 8.2F%.

The California Budget Acts of 2021 (SB 129) and 2022 (SB154) provided funding to begin implementation of the rate models as described in the 2019 Rate Study:

- Effective as of April 1, 2022: individual respite providers with rates set in statute received an increase equal to 25 percent of the difference between the rate that was effective on March 31, 2022, and that of the regional center specific rate model for the corresponding service.
- Effective as of January 1, 2023: individual respite providers with rates set in statute will receive an increase equal to 50 percent of the difference between the rate that was effective on March 31, 2022, and that of the regional center specific rate model for the corresponding service.
- Effective January 1, 2024, the rate model for Independent Living Program Providers will be increased based on updated wage assumptions which reflect more equivalent occupations and duties performed by those occupations.

No reductions will occur for provider rates already above the rate recommended by the rate study. The updated rates, listed by regional center, can be found at: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/rates-by-regional-center/

**3) ARM Methodology** - As described on pages 73-74a above. This methodology is applicable to respite facilities that also have rates established with this methodology for "Habilitation-Community Living Arrangement Services." The daily respite rate is calculated as 1/21 of the established monthly ARM rate. This methodology applies to Foster Family Agency/Certified Family Home, Foster Family Home, Small Family Home, Group Home, Adult Residential Facility, Residential Care Facility for the Elderly, Adult Residential Facility for Persons with Special Health Care Needs and Family Home Agency. If the facility does not have rate for "Habilitation-Community Living Arrangement Services" using the ARM methodology, then rates are set using #5 below.

Chapter 28, Statutes of 2019 (SB 81, Committee on Budget and Fiscal Review), authorized funding for rate increases. Rates in effect as of October 1, 2021 for Supported Employment Programs includes an increase of 7.60%.

The California Budget Act of 2021 (SB 129) and 2022 (SB154) provided funding to begin implementation of the rate models as described in the 2019 Rate Study:

- Effective as of April 1, 2022, Supported Employment (Individual) providers with rates set in statute received an increase equal to 25 percent of the difference between the rate that was effective on March 31, 2022, and that of the regional center specific rate model for the corresponding service.
- Effective as of January 1, 2023: Supported Employment (Individual) providers with rates set in statute will receive an increase equal to 50 percent of the difference between the rate that was effective on March 31, 2022, and that of the regional center specific rate model for the corresponding service.

No reductions will occur for provider rates already above the rate recommended by the rate study. The updated rates, listed by regional center, can be found at:
https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/rates-by-regional-center/

**2)** Incentive payments will be paid to service providers. Incentive payments include 1) A one-time. payment of $1,000 made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days. 2) An additional one-time payment of $1,250 made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $1,500 made to a provider when an individual has been employed consecutively for one year.

Effective as of October 1, 2021, until June 30, 2025, incentive payments will be paid to service providers. Incentive payments include 1) A one-time payment of $2,000 made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days. 2) An additional one-time payment of $2,500 made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $3,000 made to a provider when an individual has been employed consecutively for one year.

In addition, after a provider assists four individuals to achieve competitive integrated employment, for each individual thereafter, an additional payment is made to provider consisting of:

- $500 for achieving competitive integrated employment after 30 consecutive days. $1000 for continued employment for six (6) months.

For each individual who exits an internship and subsequently obtains competitive integrated employment, an additional payment is made to provider consisting of:

- $500 for achieving competitive integrated employment after 30 consecutive days. $500 for continued employment for six (6) months.

**3)** Individual Providers (Participant Directed) – $30.54 per hour, effective January 1, 2024.

**REIMBURSEMENT METHODOLOGY FOR ENHANCED HABILITATION – PREVOCATIONAL SERVICES**

There are three rate setting methodologies for this service:

**1)** Daily rates for Work Activity Program providers are set using the cost statement methodology, as described on pages 70a-71a, with the exception that the SB 81 (Committee on Budget and Fiscal Review) rate increase does not apply. The Work Activity Program rate schedule can be found at the following link. The rate schedule is effective April 1, 2022. https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/rates-by-regional-center/