CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

March 29, 2024

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 24-0006: RATE REFORM FULL IMPLEMENTATION AND GROUP HOMES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Dear Mr. Scott:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 24-0006 for your review and approval. This SPA proposes to complete the full implementation of the Rate Reform. This SPA also proposes to add group homes for children with special health care needs as a new service provider and add participant directed as a service delivery method for Self-directed Support Services. DHCS seeks an effective date of July 1, 2024, for this SPA.

This SPA proposes to complete the full implementation of the Rate Reform, making edits to the following pages:

- Attachment 3.1-i: 25, 25a, 111a, 111b, 112, 113
- Attachment 4.19-B: 70, 70a, 71, 71a, 72a, 72b, 73, 74, 74a, 75, 78, 78a, 78a-1, 78b, 78d, 78e, 78e-1, 78f, 78f-1, 78g, 78g-1, 78h, 78i, 78j, 78j-1, 78k, 78l.

In addition, CMS approved the Tribal no-notice on January 30, 2024. DHCS released a public notice on February 6, 2024. The Department received a total of nine comments. No changes were made to the amendment as a result of these comments.

The following documents are included in this submission:

- CMS 179 Form
- Fiscal Impact Summary
- Public Notice
- No-Tribal 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]

Tyler Sadwith
State Medicaid Director

Enclosures

cc: Lindy Harrington
Assistant State Medicaid Director
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0006

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
1915(i) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023-24 $ 33,600,000
b. FFY 2024-25 $ 144,600,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i: 25, 25a, 111a, 111b, 112, 113, Attachment 4.19-B: 70, 70a, 71, 71a, 72, 72a, 72b, 73, 74, 74a, 75, 78, 78a, 78a-1, 78b, 78d, 78e, 78e-1, 78f, 78f-1, 78g, 78g-1, 78h, 78i, 78j, 78j-1, 78k, 78l

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i: 25, 111b, 112, 113, Attachment 4.19-B: 70, 70a, 71, 71a, 72, 72a, 72b, 73, 74, 74a, 75, 78, 78a, 78a-1, 78b, 78d, 78e, 78e-1, 78f, 78f-1, 78g, 78g-1, 78h, 78i, 78j, 78j-1, 78k, 78l

9. SUBJECT OF AMENDMENT
Adding group homes for children with special health care needs as a new provider type, adding participant-directed as a service delivery method for self-directed support services. Complete the full implementation of the rate model as described in the DDS 2019 rate study subject to continued statutory authority to fully implement on July 1, 2024.

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
Please note: The Governor's Office does not wish to review the State Plan Amendment.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Tyler Sadwith

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
March 29, 2024

15. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

	CCLD as to type of facility As appropriate, a business license as required by the local jurisdiction where the business is located.		Section 1562.3 of the Health and Safety Code without exception, 2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following: a) A licensed registered nurse. b) A licensed nursing home administrator. c) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities. d) An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs. Maintain standards identified in "Needs-Based Evaluation/Reevaluation" item #8.
Group Homes for Children with Special Health Care Needs (GHCSHN)	Licensed Group Home for Children with Special Health Care Needs by the Department of Social Services pursuant to Health and Safety Code § 1567.51(b) As appropriate, a business license as required by the local jurisdiction where the business is located.	Per Health and Safety Code §1567.51, the State Department of Developmental Services shall be responsible for granting the certificate of program approval.	Welfare and Institutions Code, § 4684.50 et seq. The administrator must: 1. Complete the 40-hour administrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1522.41 of the Health and Safety Code without exception 2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following: a. A licensed registered nurse. b. A licensed nursing home administrator. c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities. d. An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	AFH Title 17, CCR, §56088 Authorizes the FHA to issue a Certificate of Approval to each family home which has: 1. Completed the criminal record review. 2. Been visited by the FHA and a determination ensuring safe and reasonable and the	Welfare and Institutions Code 4689.1-4689.6 provides definition and statutory authority for FHA. FHA employs sufficient staff with the combined experience, training and education to perform the following duties: 1. Administration of the FHA; 2. Recruitment of family homes; 3. Training of FHA staff and family homes; 4. Ensuring an appropriate match between the needs and preferences of the consumer and the family home; 5. Monitoring of family homes;

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

Service Title: **Self-Directed Support Services**

Service Definition (Scope)*:*
This service guides and assists the individual and/or the participant's family or representative, as appropriate, in arranging for, directing, and managing their services. With planning team oversight, providers assist the participant or family in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage 1915i services. In addition, this service provides training on managing an annual budget for service expenditures.

This service is available to consumers who have identified an interest in self-directing some or all their services. Assistance provided to participants and/or their families consists of guidance and advisement in ensuring a thorough understanding of responsibilities involved with self-direction of services, to make informed planning decisions about services and supports through the person-centered planning process, development of their initial budget and spending plan, and appropriate practices of hiring, managing, and communicating with staff. The extent of the assistance furnished to the participant or family is specified in the Individual Program Plan (IPP).
This service does not duplicate, replace, or supplant other 1915i services, including casemanagement.

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):

This service is limited to 40 hours per consumer annually. Additional hours must be reviewed by the Department and maybe authorized if deemed necessary to meet the needs of the consumer.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	Completion of a training course about the principles of participant-directed services.	

Individual	An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	Completion of a training course about the principles of participant-directed services.	

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Business entity/ individual	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and biennially thereafter.

Service Delivery Method. *(Check each that applies)*:

☒	Participant-directed	☒	Provider managed

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

Service Title:	**Technology Services**
Service Definition (Scope)*:*	

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, self-directed support services, supported employment individual and Habilitation day services, Participant-directed 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 services, respite, financial management services, family support services, self-directed 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.

	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)*:

4. **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	☒	☐
Self-directed Support Services	☒	☐
Participant-directed Services	☐	☒

5. 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.

☒**6. 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.

7. **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):*

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.

Usual and Customary Rate Methodology – A usual and customary rate "means the rate which is regularly charged by a vendor for a service that is used by both regional center consumers and/or their families and where at least 30% of the recipients of the given service are not regional center consumers or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a regional center consumer and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual with a developmental disability who is not a regional center consumer, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act."

Rate model fee schedule methodology – 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); 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. Effective July 1, 2024, the Rate Model Fee Schedules will be fully implemented as described below. The full implementation of the rate models will not result in any rate reductions for service providers. The rate models will be implemented using two components, a base rate equaling 90 percent of the regional center specific rate model, and a supplemental payment, equaling up to 10 percent of the rate model, to be implemented through the quality incentive program described below. The rate models will be updated based on changes to California Minimum Wage and/or changes to federal mileage reimbursement rates. The rate model will be implemented as follows:

- Rate Model Fee Schedules: Effective July 1, 2024, all providers included in the Rate Study will have their rates set at 90% of rate study benchmark, with the opportunity to earn the remaining 10% through the quality incentive program described below. Exceptions:
    - Rates in effect 6/30/24 will remain the same for existing providers whose rates are above 90% of the benchmark. Providers whose rates are between 90% and 100% will have the opportunity to earn the amount remaining to equal the benchmark through the quality incentive program described below. On July 1, 2026, the providers' rates will adjust to equal the rates for other providers in the providers' service category and region. Fee schedules are available by regional center at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/
- Quality Incentive Program (QIP): The initial phase of the QIP will establish the foundation for future quality measures and will focus on building capacity, developing reporting systems and gathering baseline data while working towards meaningful outcome measures at the individual consumer level for all services.

Effective July 1, 2024, providers may earn supplemental payments under this phase of the QIP by taking part in the creation of a statewide provider service directory. This service directory will bring statewide consistency and access to provider data to a variety of users including the state, regional centers, service providers and individuals receiving services and will eventually include a series of data elements that will be used to drive quality (e.g., access, language availability, capacity). It will also form the foundation for future measures by enabling the digital, comprehensive, statewide collection of service provider data to be utilized to provide greater insight into provider networks and corporate structure and more closely monitor the availability of a variety of service providers across the state. Public facing elements of the directory will allow individuals and families to access provider information regarding the types of services offered locally and capacity to serve. As described above, providers whose rates are set at less than 100% of the rate identified in the regional center specific rate model are eligible to earn supplemental payments equal to up to 10% of the rate identified in the regional center specific rate model for participation in this initial phase of the Quality Incentive Program (QIP). Providers will be eligible to receive this supplemental payment by inputting and validating requested data, including contact information, corporate structure, and parent company specifics.

Department of Health Care Services (DHCS) Fee Schedules – Rates established by the single-state Medicaid agency for services reimbursable under the Medi-Cal program. Fee schedule rates are the maximum amount that can be paid for the service. For providers who have a usual and customary rate that is less than the fee schedule rates, the regional center shall pay the provider's usual and customary rate.
https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

Median Rate Methodology - This methodology requires that rates negotiated with new providers may not exceed the regional center's current median rate for the same service, or the statewide current median rate, whichever is lower. This methodology stipulates that "no regional center may negotiate a rate with a new service provider, for services where rates are determined through a negotiation between the regional center and the provider, that is higher than the regional center's median rate for the same service code and unit of service, or the statewide median rate for the same service code and unit of service, whichever is lower. The unit of service designation must conform with an existing regional center designation or, if none exists, a designation used to calculate the statewide median rate for the same service."

While the law sets a cap on negotiated rates, the rate setting methodology for applicable services is one of negotiation between the regional center and prospective provider. Pursuant to law and the regional center's contracts with the Department of Developmental Services regional centers must maintain documentation on the process to determine, and the rationale for granting any negotiated rate (e.g. cost-statements), including consideration of the type of service and any education, experience and/or professional qualifications required to provide the service. Providers maintain their initially negotiated rate unless there is a need for an increase to protect beneficiary health and safety, as described below.

Exceptions to the median rate limit are allowed if the regional center demonstrates that an increase above the median rate limit is necessary to protect a beneficiary's health and safety. The Department of Developmental Services can grant prior written authorization to the regional center to negotiate the reimbursement rate up to the actual cost of providing the service. In the process of establishing a negotiated rate, the regional center can require documentation such as cost statements or other financial documents to determine the actual cost to provide services. Additionally, providers would be required to submit education credentials or qualifications of the various classifications that would be providing services. This information would help inform the regional center when negotiating a rate with the provider, but not exceeding the median rate.

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REIMBURSEMENT METHODOLOGY FOR HABILITATION – COMMUNITY LIVING ARRANGEMENT SERVICES

This service contains the following two subcomponents:

A. **Licensed/Certified Residential Services** – Providers in this subcategory utilize the following rate methodologies:

1. **Rate Model Fee Schedule Methodology** as described previously – This rate methodology is used for Foster Family Agency-Certified Family Homes (Children Only), Foster Family Homes (FFH) (Children Only), Small Family Homes (Children Only), Group Homes (Children Only), Adult Residential Facilities (ARF) , Residential Care Facility for the Elderly (RCFE), Family Home Agency (FHA), Adult Family Home (AFH)/Family Teaching Home (FTH), and In-Home Day Program.
2. **Specialized Licensed Residential Rate Methodology**: This methodology is used when the needs of individuals living in licensed residential settings exceed the level of support reflected in the pre-defined rate model fee schedules for community living arrangement services. The rate model fee schedule has a standard number of hours, staffing levels and qualifications of staff; when the needs of the individuals exceed these standards, this specialized rate methodology builds upon those created for the rate model fee schedules by including variable inputs for the number of staffing hours, consultation hours, and specialized personnel qualifications, with set assumed costs for these components. The following provider types use the specialized licensed residential rate methodology: Adult Residential Facility for Persons with Special Health Care Needs, Group Home for Children with Special Health Care Needs, and licensed/certified residential providers where as described above existing rate models do not reflect the level of support that individuals living in the home require. This rate methodology is available by regional center at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/
3. **Out-of-State Rate Methodology** - This methodology is applicable for out-of-state residential providers. The rate paid is the established usual and customary rate for that service, paid by that State in the provision of that service to their own service population.

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4. **Enhanced Behavioral Supports Homes (Vendor-Operated) Rate Methodology -** There are two components to the monthly rate for Enhanced Behavioral Supports Homes

1) the facility component: The allowable costs used to calculate the facility component include payroll costs of facility staff and facility related costs such as lease, facility maintenance, repairs, cable/ internet, etc. The facility rate is a negotiated amount based on cost estimates. The provider submits a facility budget to the regional center and the two determine a rate based upon where the facility is located (cost of living, lease, electricity, garbage, county minimum wage rates, the qualification of staff and consultants, and payroll costs). After detailed regional center review, that budget is then sent to the State department for further review and evaluation. The State department then analyzes the rates for each line item and compares it to the state average of other EBSHs. The provider is required to justify all costs and provide explanations of any estimated costs. The rate is effective upon approval from the state and providers are notified in writing by the vendoring regional center. As part of the certification process for Enhanced Behavioral Support Homes (EBSHs), the Department reviews the proposed facility component rate and supporting documentation for each EBSH and compares it to state averages to determine if the included costs are reasonable and economical. All rates must be approved by the Department director prior to the delivery of service at each EBSH. Rates are not reviewed annually, only as required and as agreed upon by the vendoring regional center. The state continues to receive the previous year's rate until the new rate is needed. Salaries are based upon the geographical area and the experience, education, and professional licensures held. Rate updates can happen due to cost changes in approved or active providers. For example, an increase can occur due to an increase in a vendor's lease or where another cost was higher than expected. The facility is required to show the Department their lease and contract. If the facility has an unexpected increase, they must justify the need for an increased budget and show that the cost is higher. Once the Department approves the budget an approval letter is generated to the regional center and a copy is sent to the provider. The regional center may submit a new budget to the Department for review and approval of any updates to the rate. When a rate is updated, the new rate is effective once the state department approves. A letter is sent out to the facility approving the new rate. The initial rate is effective upon the first consumer's admission into the facility.

Maximum rates may not exceed the rate limit determined by the department and administrative costs may not exceed 15%. It takes from 1-3 months to set a facility rate depending on the review process. The department may take up to three months due to additional documentation requests to ensure the accuracy of the rate requested.

Prior to submission of claims for reimbursement, the state uses the following steps to determine the portion of the claim that is eligible for federal reimbursement, using information submitted at the time of facility rate approval:

Step 1: Costs are identified as direct or indirect, consistent with cost principles in 45 CFR Part 75
Step 2: Costs are identified as allowable or unallowable (room and board), consistent with the above cost principles

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) - The rates for supported living providers are set using the Rate model fee schedules, as described previously. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

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 when providers do not have a usual and customary rate.

Rate Model Fee Schedules: as described previously, apply to the following: Community-Based Day Services: Activity Center, Adaptive Skills Trainer, Adult Developmental Centers Community Integration Training Programs, Community Activities Supports Services, Behavior Management Program providers, Independent Living Programs, and Social Recreation Programs. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Median rates: as described previously, are used to determine the applicable rate for Creative Arts Programs and Socialization Training Program.

Individual Providers (Participant-Directed) –

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

B. Therapeutic/Activity-Based Day Services – When the following providers in this subcategory do not have a usual and customary rate, the rate methodology is as follows:

Median rates: as described previously, are used to determine the rate for Specialized Recreational Therapist, Special Olympics, Sports Club, Art Therapist, Dance Therapist, Music Therapist and Recreational Therapist.

C. Mobility Related Day Services – When the following providers in this subcategory do not have a usual and customary rate, the rate methodology is as follows:

Rate Model Fee Schedules: as described previously, apply to the following: Driver Trainer, Mobility Training Services Agency and Mobility Training Services Specialist. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

REIMBURSEMENT METHODOLOGY FOR HABILITATION - BEHAVIORAL INTERVENTION SERVICES

This service is comprised of the following two subcomponents:

A. Non-Facility-Based Behavior Intervention Services– If the provider does not have a usual and customary rate as described above, then the rate is established as described below:

Rate Model Fee Schedule: The following providers use the Rate Model Fee Schedules: Behavior Analyst, Associate Behavior Analyst, Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker), Behavior Management Consultant: Licensed Clinical Social Worker, Behavior Management Consultant: Psychologist, Behavior Management Consultant: Marriage Family Child Counselor, Psychiatrist, Licensed Psychiatric Technician, Client/Parent Support Behavior Intervention Training, Parenting Support Services Provide, and Individual or Family Training Provider. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Median Rate: The following provider types have rates set via the Median rate methodology: crisis team-evaluation and behavior intervention, Family Counselor (MFCC), Marriage & Family Therapist, Psychologist, Social Worker, Clinical Social Worker (CSW), and Chemical Addition Counselor.

DHCS Fee Schedules - The fee schedule rates for Non-Facility-Based Behavior Intervention Services, Psychiatrist and Licensed Psychiatric Technician, were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

B. Crisis Intervention Facility – If the provider does not have a usual and customary rate as described above, then the rate is established as described below:

Median Rate: The rates for Crisis intervention Facilities are set via the Median rate methodology when they do not have a “usual and customary rate”.

Community Crisis Homes (Vendor-Operated) Rate Methodology - There are three components to the monthly rate for Community Crisis Homes:

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a) the facility component: the allowable costs used to calculate the facility component include payroll costs of facility staff and facility related costs such as lease, facility maintenance, repairs, cable/internet, etc.
b) the individualized services and supports component: the allowable costs used to calculate the individualized services and supports component include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports and other consumer specific program costs, and
c) the transition plan component: the allowable costs used to calculate the transition component includes the salaries, wages, payroll taxes and benefits of direct care staff providing additional services and supports needed to support a consumer during times of transition out of the CCH.

Administrative costs for the above components may not exceed 15%.

As part of the certification process for CCHs, the Department reviews the proposed facility component rate and supporting documentation for each CCH to determine if the included costs are reasonable and economical. These rates must be approved by the Department prior to the delivery of service at each CCH. If the facility has an unexpected increase, they must justify the need for an increased budget and show that the cost is higher. The new rate is effective once the Department approves the revised budget. Note: This is not the rate that is claimed for FFP.

Prior to submission of claims for reimbursement, the state uses the following steps to determine the portion of the claim that is eligible for federal reimbursement, using information submitted at the time of facility rate approval:

Step 1: Costs are identified as direct or indirect, consistent with cost principles in 45 CFR Part 75
Step 2: Costs are identified as allowable or unallowable (room and board), consistent with the above cost principles
Step 3: Allowable indirect costs are divided by total direct costs (allowable and unallowable) to determine the indirect cost percentage.
Step 4: cost percentage is applied to all direct costs
Step 5: Allowable direct costs and the allocated indirect costs are added together to determine the federally reimbursable portion of the monthly facility rate.
Step 6: The federally reimbursable portion of the facility rate is divided by the maximum residency of the home to determine the monthly federally reimbursable per person rate of the facility.
Step 7: The individual rate associated with Medicaid-eligible individuals is submitted for federal reimbursement.

As a result of the above methodology, room and board costs, as well as the allocated portion of indirect associated with these costs, are excluded from the portion of the claim that the state submits for federal reimbursement.

Community Crisis Homes (State-Operated) Rate Methodology –

An interim rate for direct and indirect service is paid according to the methodology below: Annually, the state will reconcile costs for the year and settle costs for all overpayments and underpayments.
Specific Components:

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.

Mobile Crisis Team (State-Operated) Rate Methodology

An interim rate for direct and indirect services is paid according to the methodology below. Annually the state will reconcile costs for the year and settle costs for all overpayments and underpayments. Only costs associated with Medi-Cal eligible individuals are submitted for reimbursement.

Specific Components:

Interim rate:
Cost information consisting of the following allowable direct costs (direct services) and allowable indirect costs that meet the primary cost objective are captured via the statewide accounting system. Allowable costs are identified by applying cost principles specified at 2 CFR, part 200 as implemented by the Department of Health and Human Services at 45 CFR, part 75 and include the following:

Direct:
Monthly salaries, wages, and benefits of individuals (state employees) providing the direct service; contracted services which provide a direct service component; and payroll taxes.

Indirect:
Determined by applying the Department's cognizant agency approved indirect rate to the allowable direct costs as identified above.

Unallowable costs consistent with the Selected Items of Cost as described at 45 CFR 75.420 are excluded from the interim rate and final costs submitted for federal reimbursement.

Reconciliation:
The state reviews submitted costs for the past fiscal year and determines the costs, based on the same components described above for the interim rate. After the costs are established, claims for reimbursement are reconciled based on the actual cost of delivering the service. Federal claims are submitted if the final costs are higher than the interim rate or reimbursed to CMS if final costs are lower than the interim rate. The state is responsible for reimbursing CMS for all FFP payments for all overpayments identified.

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 and apportioning these expenses to the Medicaid program, except as expressly modified below.

REIMBURSEMENT METHODOLOGY FOR RESPITE CARE

There are two subcategories for this service.

A. In-Home Respite Care rates are set via the Rate Model Fee Schedules, described previously. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

B. Out-of-Home Respite Care – There are two rate setting methodologies for providers in this subcategory.

Rate Model Fee Schedules: Rates based on licensed residential facilities with rates set with the Rate Model Fee Schedules that also provide respite. Per Title 17, California Code of Regulations, Section 57332(c)(6), the respite rate is 1/21 of the established monthly rate for the facility.

Usual and customary rate methodology – This methodology, as described previously, applies to adult day care and camping services providers.

REIMBURSEMENT METHODOLOGY FOR ENHANCED HABILITATION – SUPPORTED EMPLOYMENT

(INDIVIDUAL)

There are three rate setting methodologies for this service:

1) Rate Model Fee Schedules, described previously, apply to providers of Supported Employment. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

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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.

Effective for services provided on or after January [ ], 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.

Effective for services provided on or after January [ ], for each individual who achieves competitive integrated employment after exiting an internship, incentive payments will be paid to service providers consisting of:

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

Effective for services provided on or after January [ ], , incentive payments will be paid for internship programs, which are job-readiness programs in integrated settings for the purposes of developing general strengths and skills that contribute to employability in paid employment in integrated community settings.

The incentive payments will be applied as follows:

- A payment of seven hundred fifty dollars ($750) shall be made to the regional center service provider if the individual remains in the internship after 30 consecutive days.
- An additional payment of one thousand dollars ($1,000) shall be made to the regional center provider for an individual as described above who remains in the internship for 60 consecutive days.

3) Individual Providers (Participant Directed) – $30.54 per hour, effective on or after January [ ].

REIMBURSEMENT METHODOLOGY FOR ENHANCED HABILITATION – PREVOCATIONAL SERVICES

There are two rate setting methodologies for this service:

Rate Model Fee Schedules: as described previously, apply to Work Activity Program providers and Supported Employment Programs. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

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.

Effective for services provided on or after January [ ], , in addition, after a provider assists four individuals to achieve competitive integrated employment for at least 30 days, 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.

REIMBURSEMENT METHODOLOGY FOR TECHNOLOGY SERVICES

There are two rate setting methodologies for this service. If the provider does not have a "usual and customary," then the maximum rate is set using the median rate setting methodology. Usual and customary and median rates are described previously.

REIMBURSEMENT METHODOLOGY FOR SELF-DIRECTED SUPPORT SERVICES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The Self- Directed Support Services fee schedule rates are available at https://www.dds.ca.gov/wp-content/uploads/2022/07/Self_Directed_Support_Services_Rates_082022.pdf and were set as of November 1, 2023 and are effective for services provided on or after that date.

REIMBURSEMENT METHODOLOGY FOR COORDINATED FAMILY SUPPORTS

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The Coordinated Family Supports fee schedule rates are available at https://www.dds.ca.gov/wp-content/uploads/2023/08/CFS-Service-Code-076-rates-1.1.23-revised-8.18.23.pdf and were set as of November 1, 2023 and are effective for services provided on or after that date.

REIMBURSEMENT METHODOLOGY FOR HOMEMAKER SERVICES

There are two rate setting methodologies for homemakers. If the provider does not have a "usual and customary" rate, then the maximum rate is established using the Rate Model Fee Schedule. Usual and customary and Rate Model Fee Schedule methodologies are described previously.

REIMBURSEMENT METHODOLOGY FOR HOME HEALTH AIDE SERVICES

DHCS Fee Schedules - As described previously. The fee schedule rates for Home Health Aide Services were set as of October 1, 2021, and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR COMMUNITY BASED ADULT SERVICES

DHCS Fee Schedules - As described previously. The fee schedule rates for Community Based Adult Services were set as of October 1, 2021, and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

The rates for PERS providers are determined utilizing the usual and customary rate methodology, as previously described.

REIMBURSEMENT METHODOLOGY FOR VEHICLE MODIFICATION AND ADAPTATION

The per modification rate for vehicle modifications is determined utilizing the usual and customary rate methodology, as described previously.

REIMBURSEMENT METHODOLOGY FOR SPEECH, HEARING LANGUAGE SERVICES

There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.

1) **DHCS Fee Schedules** - As described previously. The fee schedule rates for Speech, Hearing Language Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) **Rate Model Fee Schedules**, as described previously may be used if the provider has at least one year of experience working with persons with developmental disabilities**.**

REIMBURSEMENT METHODOLOGY FOR DENTAL SERVICES

There are two rate setting methodologies for this service:

1) **DHCS Fee Schedules** - As described previously. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) **Rate Model Fee Schedules,** as described previously, may be used if the provider has at least one year of experience working with persons with developmental disabilities.

REIMBURSEMENT METHODOLOGY FOR OPTOMETRIC/OPTICIAN SERVICES

DHCS Fee Schedules - As described previously. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION LENSES AND FRAMES

DHCS Fee Schedules - As described previously. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR PSYCHOLOGY SERVICES

There are two rate setting methodologies for this service:

1) **DHCS Fee Schedules** - As described previously. The fee schedule rates for Psychology Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) **Rate Model Fee Schedules** – as described may be used if the provider has at least one year of experience working with persons with developmental disabilities.

REIMBURSEMENT METHODOLOGY FOR CHORE SERVICES

Usual and Customary Rate Methodology - As described previously.

REIMBURSEMENT METHODOLOGY FOR COMMUNICATION AIDES

There are two rate setting methodologies for all Communication Aides providers. If the provider does not have a "usual and customary" rate, then the maximum rate is established using the median rate setting methodology."

REIMBURSEMENT METHODOLOGY FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Usual and Customary Rate Methodology - As described previously.

REIMBURSEMENT METHODOLOGY FOR NON-MEDICAL TRANSPORTATION

There are three methodologies to determine the monthly rate for this service (except individual transportation providers – see Rate based on Regional Center Employee Travel Reimbursement below).

1) Usual and Customary Rate Methodology - This methodology, as described previously, applies to transportation assistants and public transit authorities.

2) Rate Model Fee Schedules –– This methodology, as described previously is used to establish the maximum rate for the following providers: transportation company, transportation-additional component and transportation broker.

3) Rate based on Regional Center Employee Travel Reimbursement – The maximum rate paid to an individual transportation provider is the IRS standard mileage rate.

REIMBURSEMENT METHODOLOGY FOR NUTRITIONAL CONSULTATION

Usual and Customary Rate Methodology - As described previously.

REIMBURSEMENT METHODOLOGY FOR SKILLED NURSING

DHCS Fee Schedules - As described previously. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

DHCS Fee Schedules - As described previously. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR TRANSITION/SET-UP EXPENSES

Usual and Customary Rate Methodology - As described previously.

REIMBURSEMENT METHODOLOGY FOR COMMUNITY-BASED TRAINING SERVICES

The rates for this service are set via the Rate Model Fee Schedules, described previously.

REIMBURSEMENT METHODOLOGY FOR FINANCIAL MANAGEMENT SERVICES

Rates for FMS are set in State regulation as follows:

If the FMS functions as a fiscal/employer agent, the rate is based on the number of participant- directed services used by the consumer:

A. A rate not to exceed a maximum of $45.88 per consumer per month for one participant-directed service; or
B. A rate not to exceed a maximum of $71.73 per consumer per month for two or three participant-directed services; or
C. A rate not to exceed a maximum of $96.86 per consumer per month for four or more participant directed services.

If the FMS functions as a co-employer, the rate is not to exceed a maximum of $96.86 per consumer per month.

REIMBURSEMENT METHODOLOGY FOR INTENSIVE TRANSITION SERVICES

In effect as of October 1, 2021, the permanent, single statewide rate for Intensive Transition services and supports will be established using the average cost of services rendered to Medi-Cal beneficiaries in state fiscal year 2019-20. The costs used to calculate the rate are salaries, wages, payroll taxes, and benefits of direct care staff providing Intensive Transition services and supports, in addition to direct care staff travel and operating costs (consisting of office lease, communications, equipment, office supplies, liability insurance, property insurance, training expenses, independent audit, and general administrative costs consistent with 45 CFR Section 75.414). needed to support a consumer during a transition. The costs will be drawn from actual expenditures as reported by providers of ITS services. Upon regional center approval, the

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providers of this service will be informed of the rate in writing. This rate will be used for all ITS vendors including any new vendors that get vendored after 2019-20.

Components of this service are assessments; substance use and recovery treatment, anger management, self-advocacy, medication management, health and dietary education, sex education, fostering healthy relationships, behavioral support and modification training for the individual, outpatient therapy, co-occurring disorders integrated treatment, and transition planning. This service is paid as a monthly unit. Any provider delivering services through ITS will be billed and paid through the ITS agency and not individually. If a provider delivers services outside of the ITS services agency purview, that provider should bill such services separately. At least one of the services included in ITS must be provided per month for the ITS agency to bill for payment. The regional center conducts yearly monitoring of the IPP to ensure services are needed and that also includes a verification of rates paid in accordance with the approved payment methodology. The IPP process includes initial and ongoing review on no later than an annual basis to ensure that services are provided efficiently and continue to meet the individual need of the consumer. Additionally, service-specific plans from the provider that demonstrate the frequency and manner in which services are actually provided are reviewed on no less than a quarterly basis.

Computation of allowable costs and their allocation methodology 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. The state assures that it will only begin seeking Federal Financial Participation for ITS once an individual is eligible to receive the service.

REIMBURSEMENT METHODOLOGY FOR HOUSING ACCESS SERVICES

The rate for Housing Access Service is determined utilizing the Usual & Customary rate methodology as previously described.

REIMBURSEMENT METHODOLOGY FOR FAMILY SUPPORT SERVICES

There are two rate setting methodologies for this service. If the provider does not have a “usual and customary,” then the maximum rate is set using the median rate setting methodology.

REIMBURSEMENT METHODOLOGY FOR OCCUPATIONAL THERAPY

There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.

1) DHCS Fee Schedules - As described previously. The fee schedule rates for Occupational Therapy Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) Rate model fee schedule - as described previously may be used if the provider has at least one year of experience working with persons with developmental disabilities.

REIMBURSEMENT METHODOLOGY FOR PHYSICAL THERAPY

There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.

1) DHCS Fee Schedules - As described previously. The fee schedule rates for Physical Therapy Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) Rate model fee schedule - as described previously may be used if the provider has at least one year of experience working with persons with developmental disabilities.

REIMBURSEMENT METHODOLOGY FOR FAMILY/ CONSUMER TRAINING

There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.

1) DHCS Fee Schedule - as described previously.

2) Rate Model Fee Schedules – as described previously, may be used if the provider has at least one year of experience working with persons with developmental disabilities.