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State/Territory Name: California

State Plan Amendment (SPA) #: 16-047

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

April 7, 2017

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 16-0047, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 21, 2016. This amendment adds the following to the 1915(i) State Plan Home and Community-Based Services (HCBS) renewal: a median rate methodology for licensed/certified residential services; participant direction as an option for existing respite, skilled nursing, and non-medical transportation services; and new community-based training and financial management services.

This SPA has an effective date of October 01, 2016 and an expiration date of September 30, 2021. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-i, pages 1, 4, 12, 12a, 40-45, 47, 48, 75, 78, 86a, 86a.1, 86b-86e, 87, 88, 88a
- Attachment 4.19-B, pages 71, 73, 77c

If you have any questions, please contact Adrienne Hall at 415-744-3674 or via email at Adrienne.Hall@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Joseph Billingsley, DHCS
Jalal Haddad, DHCS
Kathyryn Waje, DHCS
Wendy Ly, DHCS
Nathaniel Emery, DHCS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
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DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

April 7, 2017

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of State Plan Amendment (SPA) 16-0047, which was submitted to CMS on November 21, 2016.

The approval of SPA 16-0047 updates the §1915(i) State Plan Home and Community-Based Services Benefit to add the following items: a median rate methodology for Licensed/Certified Residential Services; participant direction as an option for respite, skilled nursing, and non-medical transportation services; and Community-Based Training Service and Financial Management Services to the state plan. As part of our review of SPA 16-0047, we found that California's existing state plan language for Respite Care on Attachment 3.1-i page 39 authorizes "Family Support Respite – Regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home." CMS noted that this language could be interpreted as covering typical child care under Respite Care services, which is not reimbursable with federal funds. We further note that this is an issue that the state is currently addressing in the state's 1915(c) HCBS waivers.

Regulations at 42 CFR 430.10 require that the state plan be a comprehensive written statement describing the nature and scope of the state's Medicaid program and that it contain all information necessary for CMS to determine whether the plan can be approved to serve as the basis for federal financial participation (FFP) in the state program. Accordingly, please submit an amendment to the state's approved 1915(i) benefit to address the following comments:

1. **Attachment 3.1-i, Respite Care on page 39:** This page was not included as part of the original SPA 16-0047 but is in the current California state plan and includes language that needs to be clarified. Please specify in the Respite Care definition that the purpose of this service is to relieve the caregiver on a temporary/short term basis. Also, please remove/do not include references to the respite service including regularly scheduled/provided care and supervision.

2. **Attachment 3.1-i, Respite Care limits on page 40:** This page was included as part of the original SPA 16-0047 and must also be revised given the above issue with Respite Care

services as currently defined in the state plan. The statement that "Service limitations do not apply to family support respite" does not align with the temporary nature of this service. Please specify the limits on family support respite as well since respite is a temporary/short term service. If the state wishes to establish a service delivered on a regularly scheduled basis, then this service would no longer be considered respite as it is not temporary/short term and would also be subject to the settings requirements.

Please submit the amendment within 90 days of this companion letter. During the 90-day period, we are happy to provide any technical assistance that you need.

If you have any questions, please contact Adrienne Hall at 415-744-3674 or via email at Adrienne.Hall@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Jacey Cooper, DHCS, Long-Term Care Division (LTCD)
Joseph Billingsley, DHCS, LTCD
Jalal Haddad, DHCS, LTCD
Lindsay Jones, DHCS, LTCD
Nathaniel Emery, DHCS
Kathyryn Waje, DHCS

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: 16-047

2. STATE: CA

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
1915i of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 2016-17 $ ~~11,350,000~~ **12,567,000**
b. FFY 2017-18 $ ~~11,690,000~~ **12,944,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, pages 1, 41, 42, 44, 45, 47, 48, 75, 78, 79, 86a, 86b, 86c, 86d, 86e, 87, 88, 88a
Attachment 4.19-B, pages 71, 73, 77c
Attachment 3.1-i pages cont'd: 4, 12, 12a, 40, 43, and 86a.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, pages 1, 41, 42, 44, 45, 47, 48, 75, 78, 79, 86a, 86b, 87, 88, **4, 12, 40, 43**
Attachment 4.19-B, pages 71, 73, 77c

10. SUBJECT OF AMENDMENT
1915i SPA renewal - adds participant direction ~~of services as an option to include~~ **^option for Respite, Skilled Nursing, Non-Medical Transportation,** Community-Based Training and Financial Management Services

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
Chief Deputy Director

15. DATE SUBMITTED
NOV 21 2016

16. RETURN TO
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, MS 4506
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
11/21/2016

18. DATE APPROVED
April 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/2016

20. SIGNATURE OF REGIONAL OFFICIAL
/s/

21. TYPED NAME
Henrietta Sam-Louie

22. TITLE
Associate Regional Administrator

23. REMARKS
Boxes 7-10 revisions made per CMS request. CA approval dated 03/07/17.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

1915(i) HCBS State Plan Services Administration and Operation

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; Supported Employment- Group; 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; Specialized Therapeutic Services; Transition/Set-Up Expenses; Community-Based Training Services; Financial Management Services

2. State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package. *(Select one)*:

○	The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)*	
◉	The HCBS state plan supplemental benefit package is operated by *(name of agency)*	
	The Department of Developmental Services (DDS)	
	a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

3. Distribution of State Plan HCBS Operational and Administrative Functions.

☑ The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.

6. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually. *(Specify):*

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2016	9/30/2017	49,000
Year 2	10/1/2017	9/30/2018	50,000
Year 3	10/1/2018	9/30/2019	51,000
Year 4	10/1/2019	9/30/2020	52,000
Year 5	10/1/2020	9/30/2021	53,000

2. ☑ **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

2. Medically Needy. *(Select one)*

○	The State does not provide HCBS state plan services to the medically needy.
◉	The State provides HCBS state plan services to the medically needy *(select one):*
	○ The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	◉ The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. Responsibility for Performing Evaluations / Reevaluations. Independent evaluations/reevaluations to determine whether applicants are eligible for HCBS are performed (*select one*):

○	Directly by the Medicaid agency

on a year-for-year basis.

4. **Responsibility for Service Plan Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

5. **Supporting the Participant in Service Plan Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The service plan, commonly referred to as the individual program plan (IPP), is prepared jointly by the planning team, which at minimum includes the individual or, as appropriate their parents, legal guardian or conservator, or authorized representative and a representative from the regional center. When invited by the individual, others may join the planning team.

The IPP is developed through a person-centered process of individualized needs determination with the opportunity for active participation by the individual/representative in the plan 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, 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

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 the requirement to use and assistance 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.

- Other community setting approved by the State that is not a private residence, such as:
  - Adult Family Home/Family Teaching Home
  - Certified Family Homes for Children
  - Adult Day Care Facility
  - Camp
  - Child Day Care Facility
  - Licensed Preschool

A regional center may offer family members or adult consumers the option to self-direct their own respite services.
Respite services do not duplicate services provided under the Individuals with Disabilities Education (IDEA) Act of 2004.

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

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.
☑	Medically needy *(specify limits):*
	A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual	No state licensing category. As appropriate, a business license as required by the local jurisdiction.	N/A	Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross; and has the skill, training, or education necessary to perform the required services.

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	where the business is located.		
Respite Agency	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	The agency director shall possess at a minimum: 1. A bachelor's degree and a minimum of 18 months' experience in the management of a human services delivery system, or; 2. Five years of experience in a human services delivery system, including at least two years in a management or supervisory position.
Adult Day Care Facility	Health and Safety Code §§ 1500 - 1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	The administrator shall have the following qualifications: 1. Attainment of at least 18 years of age. 2. Knowledge of the requirements for providing the type of care and supervision needed by clients, including ability to communicate with such clients. 3. Knowledge of and ability to comply with applicable law and regulation. 4. Ability to maintain or supervise the maintenance of financial and other records. 5. Ability to direct the work of others, when applicable. 6. Ability to establish the facility's policy, program and budget. 7. Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff, if applicable to the facility. 8. A baccalaureate degree in psychology, social work or a related human services field and a minimum of one-year experience in the management of a human services delivery system; or three years of experience in a human services delivery system including at least one year in a management or supervisory position and two years of experience or training in one of the

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			following: A. Care and supervision of recipients in a licensed adult day care facility, adult day support center or an adult day health care facility. B. Care and supervision of one or more of the categories of persons to be served by the center. The licensee must make provision for continuing operation and carrying out of the administrator's responsibilities during any absence of the administrator by a person who meets the qualification of an administrator.
Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)	FFA licensed pursuant to Health and Safety Code §§1500-1567.8 provides statutory authority for DSS licensing of facilities identified in the CA Community Care Facilities Act. As appropriate, a business license as required by the local jurisdiction where the business is located.	Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes.	Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA's, certification and use of homes, FFA administrator qualifications: (1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or, (2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position. Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).
Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only) Payment for this	Health and Safety Code §§1500-1567.8 As appropriate, a business license as	N/A	Title 22, CCR §§89200-89587.1 Regulations adopted by DSS to specify requirements for licensure of Foster Family Homes. Qualifications/Requirements for FFH providers:

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service will not be duplicated or supplanted through Medicaid funding.	required by the local jurisdiction where the business is located.		1. Comply with applicable laws and regulations and: 2. Provide care and supervision to meet the child's needs including communicating with the child; 3. Maintain all child records, safeguard cash resources and personal property; 4. Direct the work of others in providing care when applicable, 5. Apply the reasonable and prudent parent standard; 6. Promote a normal, healthy, balanced, and supported childhood experience and treat a child as part of the family; 7. Attend training and professional development; 8. Criminal Records/Child Abuse Registry clearance; 9. Report special incidents; 10. Ensure each child's personal rights; and, 11. Maintain a clean, safe, health home environment.
Respite Facility; Residential Facility: Small Family Homes (Children Only)	Health and Safety Code §§1500-1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR §§ 83000-83088. Regulations adopted by DSS to specify requirements for licensure of Small Family Homes. Licensee/Administrator Qualifications ▪ Criminal Records/Child Abuse Index Clearance; ▪ At least 18 years of age; ▪ Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours is not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted: o Child Development; o Recognizing and/or dealing with learning disabilities;

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			o Infant care and stimulation; o Parenting skills; o Complexities, demands and special needs of children in placement; o Building self-esteem, for the licensee or the children; o First aid and/or CPR; o Bonding and/or safeguarding of children's property; o Ability to keep financial and other records; o Ability to recruit, employ, train, direct the work of and evaluate qualified staff.
Respite Facility; Residential Facility: Group Homes (Children Only)	Health and Safety Code §§ 1500-1567.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Title 22, CCR, § 84000-84808 Regulations adopted by DSS to specify requirements for licensure of Group Homes. Administrator Qualifications: 1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children; 2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above); 3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or 4.Completed high school, or equivalent, plus at least three years administrative - or supervisory experience (as above); and, 5. Criminal Records/Child Abuse Registry Clearance
Respite Facility; Residential Facility: Adult Residential Facilities (ARF)	Health and Safety Code §§ 1500 through 1567.8 As appropriate, a business license as required by the local jurisdiction where the	N/A	Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception. **Administrator Qualifications** ▪ At least 21 years of age; ▪ High school graduation or a GED; ▪ Complete a program approved by DSS that consists of 35 hours of classroom instruction

	business is located.		o 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities; o 3 hrs. in business operations; o 3 hrs. in management and supervision of staff; o 5 hrs. in the psychosocial needs of the facility residents; o 3 hrs. in the use of community and support services to meet the resident's needs; o 4 hrs. in the physical needs of the facility residents; o 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents; o 4 hrs. on admission, retention, and assessment procedures; ▪ Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%. ▪ Criminal Record/Child Abuse Registry Clearance. **Additional Administrator Qualifications may also include**: ▪ 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.

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			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.
Respite Facility; Residential Facility: 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 prospective providers experience, knowledge, cooperation, history and interest to become an approved family home. 3. Completed required orientation and training.	Welfare and Institutions Code 4689.1-4689.6 provides 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; 6. Provision of services and supports to consumers and family homes which are consistent with the consumer's preferences and needs and the consumer's IPP; and 7. Coordination with the regional center and others. In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.
Camping Services	As appropriate, a business license as required by the local jurisdiction where the business is located.	The camp submits to the local health officer either 1) Verification that the camp is	Camp Director Qualifications: must be at least 25 years of age, and have at least two seasons of administrative or supervisory experience in camp activities. Health Supervisor (physician, registered

	where the business is located.	accredited by the American Camp Association or 2) A description of operating procedures that addresses areas including supervisor qualifications and staff skill verification criteria.	nurse or licensed vocational nurse) employed full time will verify that all counselors have been trained in first aid and CPR.
Child Day Care Facility Child Day Care Center; Family Child Care Home	Health and Safety Code §§ 1596.90 – 1597.621 As appropriate, a business license as required by the local jurisdiction where the business is located.	Child Day Care Center: Title 22 CCR, §§101151-101239.2 Family Child Care Home: Title 22 CCR §§102351.1-102424	The administrator shall have the following qualifications: 1. Attainment of at least 18 years of age. 2. Knowledge of the requirements for providing the type of care and supervision children need and the ability to communicate with such children. 3. Knowledge of and ability to comply with applicable law and regulation. 4. Ability to maintain or supervise the maintenance of financial and other records. 5. Ability to establish the center's policy, program and budget. 6. Ability to recruit, employ, train, direct and evaluate qualified staff.

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):*
All respite providers	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 ongoing thereafter through oversight and monitoring activities.

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	registration with the State of California as appropriate for the type of modification being purchased.		

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

Provider Type *(Specify):*Provider	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Contractor appropriate for the type of adaption to be completed.	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 ongoing as needed/ required.

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:	**Non-Medical Transportation**

Service Definition (Scope)*:*

Service offered in order to enable individuals eligible for 1915(i) State Plan Services to gain access to other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them.

Non-medical transportation services shall be offered in accordance with the individual's plan of care and shall include transportation aides and such other assistance as is necessary to assure the safe transport of the recipient. Private, specialized transportation will be provided to those individuals who cannot safely access and utilize public transportation services (when available.) Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. A regional center may offer family members or adult consumers the option to self-direct their own non-medical transportation 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 for *(chose each that applies):*

☐	Categorically needy *(specify limits):*

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	and duty statements; and service design.	

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:	**Skilled Nursing**

Service Definition (Scope)*:*

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. 1915(i) HCBS SPA Skilled Nursing Services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

A regional center may offer family members or adult consumers the option to self-direct their own skilled nursing 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 for *(chose 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):*
Registered Nurse (RN)	Business and Professions Code, §§ 2725-2742 Title 22, CCR, § 51067 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Licensed Vocational Nurse (LVN)	Business and Professions Code, §§ 2859-2873.7 Title 22, CCR, § 51069 As appropriate	N/A	N/A

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	business license as required by the local jurisdiction where the business is located.		
Home Health Agency: RN or LVN	Title 22, CCR, §§ 74600 et. seq. **RN:** Business and Professions Code, §§ 2725-2742 Title 22, CCR, § 51067 **LVN:** Business and Professions Code, §§ 2859-2873.7 Title 22, CCR, § 51069 As appropriate, a business license as required by the local jurisdiction where the business is located.	Medi-Cal Certification using Medicare standards Title 22, CCR, §§ 51069-51217.	N/A

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):*
All Skilled Nursing Providers	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 ongoing thereafter through oversight and monitoring activities.
Registered Nurse	Board of Registered Nursing, Licensing and regional centers	Every two years
Licensed Vocational Nurse	Board of Vocational Nursing and Psychiatric Technicians, Licensing and regional centers	Every two years

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:	**Specialized Medical Equipment and Supplies**

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	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 qualification and duty statements; and service design.	monitoring activities

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:	**Community-Based Training Service**
Service Definition (Scope)*:*	

Community-based training service is a participant-directed service that allows recipients the opportunity to customize day services to meet their individualized needs. As determined by the person-centered individual program planning process, the service may include opportunities and assistance to: further the development or maintenance of employment and volunteer activities; pursue post-secondary education; and increase recipients' ability to lead integrated and inclusive lives. These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. These services enable the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care.

Educational services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

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):*

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Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	Community-based training services are limited to a maximum of 150 hours per quarter.
☑	Medically needy *(specify limits):*
	Community-based training services are limited to a maximum of 150 hours per quarter.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community-Based Training Provider	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

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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):*
Community-Based Training Provider	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 ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:			
☑	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*

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, 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 timesheets of workers.
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.

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

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<table>
<tr><td colspan="5">Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):</td></tr>
<tr><td rowspan="2">☐</td><td colspan="4">Categorically needy (specify limits):</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>☐</td><td colspan="4">Medically needy (specify limits):</td></tr>
<tr><td colspan="3" rowspan="3">Specify whether the service may be provided by a
(check each that applies):</td><td>☐</td><td>Relative</td></tr>
<tr><td>☐</td><td>Legal Guardian</td></tr>
<tr><td>☐</td><td>Legally Responsible Person</td></tr>
<tr><td colspan="5">Provider Qualifications (For each type of provider. Copy rows as needed):</td></tr>
<tr><td>Provider Type (Specify):</td><td>License (Specify):</td><td colspan="2">Certification (Specify):</td><td>Other Standard (Specify):</td></tr>
<tr><td>Financial Management Services Provider</td><td>Business license, as appropriate</td><td colspan="2"></td><td></td></tr>
<tr><td colspan="5">Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):</td></tr>
<tr><td>Provider Type (Specify):</td><td colspan="2">Entity Responsible for Verification (Specify):</td><td colspan="2">Frequency of Verification (Specify):</td></tr>
<tr><td>All FMS providers</td><td colspan="2">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.</td><td colspan="2">Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.</td></tr>
<tr><td colspan="5">Service Delivery Method. (Check each that applies):</td></tr>
<tr><td>☑</td><td colspan="2">Participant-directed</td><td>☐</td><td>Provider managed</td></tr>
</table>

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Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*): **See attachment 4.19-B for descriptions of the rate setting methodologies for the services identified below.**

☑	Habilitation – Community Living Arrangement Services	
☑	Habilitation - Day Services	
☑	Habilitation – Behavioral Intervention Services	
☑	Respite Care	
☑	Enhanced Habilitation - Supported Employment	
☑	Enhanced Habilitation – Prevocational Services	
☐	Personal Care Services	
☑	Homemaker	
☑	Home Health Aide	
☑	Community Based Adult Services	
☑	Other Services	
	☑	HCBS Personal Emergency Response Systems –
	☑	HCBS Vehicle Modification and Adaptation –
	☑	HCBS Speech, Hearing and Language Services
	☑	HCBS Dental Services
	☑	HCBS Optometric/Optician Services
	☑	HCBS Prescription Lenses and Frames
	☑	HCBS Psychology Services
	☑	HCBS Chore Services
	☑	HCBS Communication Aides
	☑	HCBS Environmental Accessibility Adaptations
	☑	HCBS Non-Medical Transportation
	☑	HCBS Nutritional Consultation
	☑	HCBS Skilled Nursing

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	☑	HCBS Specialized Medical Equipment and Supplies
	☑	HCBS Specialized Therapeutic Services
	☑	HCBS Transition/Set-Up Expenses
	☑	HCBS Community-Based Training Services
	☑	HCBS Financial Management Services

2. Presumptive Eligibility for Assessment and Initial HCBS. Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) *(Select one):*

◉	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
○	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be [ ] days (not to exceed 60 days).

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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 HCBS state plan services (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 HCBS state plan services (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, community-based training 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 HCBS State Plan option, 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. Families and consumers will have the freedom to directly control and decision making authority over how and when the services are provided as an alternative to receiving services provided by staff hired by an authorized agency through the regional center.

For those participants who receive respite, 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 exercise decision making authority over the provision of services.

3. Participant-Directed Services. *(Indicate the 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	☑	☐

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

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
◉	Financial Management is furnished as a covered service entitled "Financial Management Service" as described in this amendment..

5. ☑ **Participant–Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

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. In some instances, there may not be agreement with the decision to terminate participant-direction of services. In these instances, the regional center would issue a notice of action and the participant would have the opportunity for a fair hearing. 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.

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7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*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 state plan 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 state plan 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). (*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 how the method makes use of reliable cost estimating information, 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 plan of care):*
	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):*

direct services for consumers as well as administrative expenses for service providers.

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.

If the regional center demonstrates an increase to the median rate 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.

REIMBURSEMENT METHODOLOGY FOR HABILITATION – COMMUNITY LIVING ARRANGEMENT SERVICES

This service contains the following two subcomponents:

A. Licensed/Certified Residential Services – Providers in this subcategory are Foster Family Agency/Certified Family Home, Foster Family Home, Small Family Home, Group Home, Adult Residential Facility, Residential Facility for the Elderly, Out-of-State Residential Facility, Adult Residential Facility for Persons with Special Health Care Needs and Family Home Agency. There are three rate setting methodologies for all providers in this subcategory.

1) Alternative Residential Model (ARM) Methodology – The ARM methodology and monthly rates resulted from an analysis of actual costs of operating residential care facilities. The applicable cost components (see below) were analyzed to determine the statistical significance of the variation in costs among facilities by service type, facility size, and operation type. Based upon the results of this statistical analysis, the initial ARM rates were determined and became effective in 1987. Within this methodology 14 different service levels were established based upon the results of this cost analysis. Individual providers can apply to become a vendor for one of these service levels based upon the staffing ratios, service design, personnel qualifications and use of consultant services as described in their program design.

The following allowable costs were used in setting the ARM rates:

- Direct costs for covered services: Includes unallocated payroll costs and other unallocated cost that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to

appropriate reimbursement levels and update the fee schedule and State Plan. If the State determines that no rebasing is necessary, the State must submit documentation to CMS to support its decision.

2) 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.

3) Median Rate Methodology - As described on pages 70-71, above. This methodology is used to determine the applicable rate for Licensed/Certified Residential Services providers.

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 70-71 above.

REIMBURSEMENT METHODOLOGY FOR HABILITATION – DAY SERVICES

This service is comprised of the following three subcomponents:

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

1) **Rates Set pursuant to a Cost Statement Methodology** – As described on page 69, 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). The rate schedule, effective July 1, 2016, for these services is located at the following link: http://www.dds.ca.gov/Rates/docs/Comm_Based_Respite.pdf

2) **Median Rate Methodology** – As described on pages 70-71, above. This methodology is used to determine the applicable daily rate for In-Home Day Program, 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.

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.

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REIMBURSEMENT METHODOLOGY FOR SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective July 15, 2016 can be found at the following link: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR SPECIALIZED THERAPEUTIC SERVICES

(including reimbursement for travel, which must be necessary and cost-effective, to a provider for providing Specialized Therapeutic Services that are outside of the individual's residence or program environment due to the disabilities of the individual)

Median Rate Methodology - As described on pages 70-71, above.

REIMBURSEMENT METHODOLOGY FOR TRANSITION/SET-UP EXPENSES

Usual and Customary Rate Methodology - As described on page 70, above.

REIMBURSEMENT METHODOLOGY FOR COMMUNITY-BASED TRAINING SERVICES

The maximum rate for this service is set pursuant to State statute [Welfare and Institutions Code Section 4688.21(c)(7)] in conjunction with the increases authorized in Sections 4691.10 and 4691.11, at $14.99 per hour.

REIMBURSEMENT METHODOLOGY FOR FINANCIAL MANAGEMENT SERVICES

Rates for FMS are set in State regulation, Title 17, CCR, Section 58888(b), in conjunction with the increases authorized by State statute [Welfare and Institutions Code Section 4691.10] 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 $71.37 per consumer per month 7 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 for one to four co-employer services.