Table of Contents

State/Territory Name: California

State Plan Amendment (SPA) #: 11-041

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

FEB 19 2014

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 11-041. SPA 11-041, submitted to my office on December 29, 2011, expands the scope of services offered under the State's existing 1915(i) State plan section that serves persons with developmental disabilities that require a level of care that is less stringent than institutional criteria.

The effective date of this SPA is October 1, 2011. Enclosed are the following approved SPA pages to be incorporated into your approved State Plan:

- Attachment 3.1-i, pages 62a-62y
- Attachment 4.1-B. pages 78-80

If you have any questions, please contact Cynthia Nanes at (415) 744-2977 or by email at Cynthia.Nanes@cms.hhs.gov.

Sincerely,

/s/
Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: John Shen, Chief, LTCD, CA DHCS
Mark Helmar, LTCD, CA DHCS
Besti Howard, LTCD, CA DHCS
Jim Knight, CA DDS
Michele MacKenzie, CMS, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-041**

2. STATE: CA

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2011 October 1, 2011

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:
Section 1915(i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2011~~ 2012 ~~$6,430,000~~ $9,392,000
b. FFY ~~2012~~ 2013 ~~$25,750,000~~ $9,200,00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 67-72 78-80
~~Attachment 3.1-C, pages 28-53~~ Attachment 3.1-i, pages 62a-62y

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None

10. SUBJECT OF AMENDMENT:

Additional Services under 1915(i) SPA

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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 12/27/11

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 29, 2011

18. DATE APPROVED: FEB 19 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Gloria Nagle, PhD, MPA

22. TITLE: Associate Regional Administrator

23. REMARKS:

Pen and Ink changes made by DHCS to boxes 4, 7 and 8.

FORM HCFA-179 (07-92)

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

Services

1. **State plan HCBS.** *(Continued from service list beginning on page 13 and ending on page 62.)*

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

Service Title: **Speech, Hearing and Language Services**

Service Definition (Scope):

Speech, Hearing and Language services are defined in Title 22, California Code of Regulations, Sections 51096, 51098, and 51094.1 as speech pathology, audiological services, and hearing aids, respectively. Speech pathology services mean services for the purpose of identification, measurement and correction or modification of speech, voice or language disorders and conditions, and counseling related to such disorders and conditions. Audiological services means services for the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and the recommendation and evaluation of hearing aids. Hearing aid means any aid prescribed for the purpose of aiding or compensating for impaired human hearing loss.

These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Speech, Hearing and Language services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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)*:
Speech Pathologist	Business & Professions Code §§ 2532-2532.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A

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

Audiology	Business & Professions Code §§ 2532-2532.8 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Hearing and Audiology Facilities	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	An audiology facility: 1. Employs at least one audiologist who is licensed by the Speech Pathology and Audiology Examining Committee of the Medical Board of California; and 2. Employs individuals, other than 1. above, who perform services, all of whom shall be: • Licensed audiologists; or • Obtaining required professional experience, and whose required professional experience application has been approved by the Speech Pathology and Audiology Examining Committee of the Medical Board of California.

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 Speech, Hearing and Language 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.
Speech Pathologist	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board	Biennially.
Audiology	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board	Biennially if non-dispensing audiologist; annually if dispensing.
Hearing and Audiology Facilities	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board	Biennially.

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

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

☐	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: **Dental Services**

Service Definition (Scope):

Dental services are defined in Title 22, California Code of Regulations, Section 51059 as professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.

These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Dental Services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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):*
Dentist	Business & Professions Code §§ 1600-1976 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	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):*

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

Dentists	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.
Dentists	Dental Board of California	Biennially

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: **Optometric/Optician Services**

Service Definition (Scope):

Optometric/Optician Services are defined in Title 22, California Code of Regulations, Sections 51093 and 51090, respectively. Optometric services means any services an optometrist may perform under the laws of this state. Dispensing optician means an individual or firm which fills prescriptions of physicians for prescription lenses and kindred products and fits and adjusts such lenses and spectacle frames. A dispensing optician is also authorized to act on the advice, direction and responsibility of a physician or optometrist in connection with the fitting of a contact lens or contact lenses.

These services will be provided to individuals age 21 and older as described in the approved State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Optometric/Optician services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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):*
Orthoptic Technician	Business and Professions Codes in Chapter 7,	An orthoptic technician is validly certified by the American	N/A

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

	Article 3 Sections 3041, 3041.3, 3056, 3057	Orthoptic Council	
Optometrist	An optometrist is validly licensed as an optometrist by the California State Board of Optometry As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	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 Optometric/Optician service 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.
Orthoptic Technician	American Orthoptic Council	Every three years
Optometrist	California State Board of Optometry	Biennially

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:	**Prescription Lenses and Frames**
Service Definition (Scope):	

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

Prescription Lens/Frames are defined in Title 22, California Code of Regulations, Section 51162. Eyeglasses, prosthetic eyes and other eye appliances means those items prescribed by a physician or optometrist for medical conditions related to the eye.

These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Prescription Lenses and Frames will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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):*
Dispensing Optician	Business and Professions Code §§ 2550-2560. As appropriate, a business license as required by the local jurisdiction where the business is located.	Registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California	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 Prescription Lens/ Frame 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	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

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

	service design.	
Dispensing Optician	Medical Board of California	Biennially

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: **Psychology Services**

Service Definition (Scope):

Psychology Services are defined in Title 22, California Code of Regulations, Section 51099 as the services of a person trained in the assessment, treatment, prevention, and amelioration of emotional and mental health disorders.

These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Psychology Services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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):*
Clinical Psychologist	Business and Professions Code, §§2940-2948 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A

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

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)*:
Clinical Psychologists	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.
Clinical Psychologist	Board of Psychology	Biennially

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:	**Chore Services**
Service Definition (Scope):	
Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, and minor repairs such as those which could be completed by a handyman. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.	
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)*:
Individual	As appropriate for the services	N/A	Individual chore service providers shall possess the following minimum qualifications:

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

	to be done. As appropriate, a business license as required by the local jurisdiction where the business is located.		1. The ability to perform the functions required in the individual plan of care; 2. Demonstrate dependability and personal integrity.

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*):
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 ongoing thereafter through oversight and 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: **Communication Aides**

Service Definition (Scope):

Communication aides are those human services necessary to facilitate and assist persons with hearing, speech, or vision impairment to be able to effectively communicate with service providers, family, friends, co-workers, and the general public. The following are allowable communication aides, as specified in the recipient's plan of care:

1. Facilitators;
2. Interpreters and interpreter services; and
3. Translators and translator services.

Communication aide services include evaluation for communication aides and training in the use of communication aides.

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*):

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

☐	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)*:
Facilitators	No state licensing category. An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	N/A	Qualifications and training as appropriate.
Interpreter	No state licensing category. An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	N/A	1. Fluency in both English and a language other than English; and 2. The ability to read and write accurately in both English and a language other than English.
Translator	No state licensing category. An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	N/A	1. Fluency in both English and a language other than English; and 2. The ability to read and write accurately in both English and a language other than English.

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 Communication Aid 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	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

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

	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: **Environmental Accessibility Adaptations**

Service Definition (Scope):

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded form this benefit. All services shall be provided in accordance with applicable State or local building codes.

It may be necessary to make environmental modifications to an individual's home before he/she transitions from an institution to the community. Such modifications may be made while the person is institutionalized. Environmental modifications, included in the individual's plan of care, may be furnished up to 180 days prior to the individual's discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is determined eligible for 1915(i) State Plan Services.

In the event an individual dies before the relocation can occur, but after the modifications have been made, the State will claim FFP at an administrative rate for services that would have been necessary for relocation to have taken place.

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):*
Contractor	A current license, certification or	See "License"	N/A

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

	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)*:	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.

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 vouchers to family members or adult consumers to allow the families and consumers to procure their own 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):*

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

☐	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):*
Individual Transportation Provider	Valid California driver's license As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Welfare and Institutions Code Section 4648.
Transportation Company: Transportation Broker; Transportation Provider–Add-itional Component	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Welfare and Institutions Code Section 4648.3.
Public Transit Authority	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Welfare and Institutions Code Section 4648.3.

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 Transportation 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.

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

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

☐	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: **Nutritional Consultation**

Service Definition (Scope):

Nutritional Consultation includes the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of the consumers. These services are consultative in nature and do not include specific planning and shopping for, or preparation of meals for consumers.

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):*
Dietitian; Nutritionist	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	Dietician: Valid registration as a member of the American Dietetic Association	Nutritionist must possess a Master's Degree in one of the following: a. Food and Nutrition; b. Dietetics; or c. Public Health Nutrition; or is employed as a nutritionist by a county health department.

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 Nutritional Consultation 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	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

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

	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 supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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, a	N/A	N/A

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

	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**

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

Service Definition (Scope):
Specialized Medical Equipment and Supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the approved Medicaid State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the approved Medicaid State plan. The repair, maintenance, installation, and training in the care and use, of these items is also included. Funding for items reimbursed by this State Plan Amendment are in addition to any medical equipment and supplies furnished under the approved Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design, and installation, and must meet Underwriter's Laboratory or Federal Communications Commission codes, as applicable. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.
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):*
Durable Medical Equipment Dealer	If applicable, a current license with the State of California as appropriate for the type of equipment or supplies being purchased. As appropriate, a business license as required by the local jurisdiction where the business is located.	If applicable, a current certification with the State of California as appropriate for the type of equipment or supplies being purchased.	Be authorized by the manufacturer to install, repair and maintain such systems if such a manufacturer's program exists.

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):*

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

All Specialized Medical Equipment and Supplies 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.

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 Therapeutic Services**

Service Definition (Scope):

Specialized Therapeutic Services are services that provide physical, behavioral/social-emotional health, and or dental health care that have been adapted to accommodate the unique complexities presented by HCBS enrolled individuals. These complexities include requiring:

1. Additional time with the health care professional to allow for effective communication with patients to ensure the most effective treatment;
2. Additional time with the health care professional to establish the patient's comfort and receptivity to treatment to avoid behavioral reactions that will further complicate treatment;
3. Additional time for diagnostic efforts due to the masking effect of some developmental disabilities on health care needs;
4. Specialized expertise and experience of the health care professional in diagnosing health care needs that may be masked or complicated by a developmental disability;
5. Treatment to be provided in settings that are more conducive to the patient's ability to effectively receive treatment, either in specialized offices or facilities that offer better structured interaction with the patient or which may provide additional comfort and support which is needed to reduce patient anxiety that is related to his or her developmental disabilities.

All of these additional elements to Specialized Therapeutic Services are designed and proven effective in ensuring the health and safety of the consumers. They are also designed or adapted with specialized expertise, experience or supports to ensure that the impact of a person's developmental disability does not impede the practitioner's ability to effectively provide treatment. The design features and/or expertise levels required by these consumers have been developed through years of experience and are not available through existing Medicaid State plan services. These features are critical to maintain, preserve, or improve the health status and developmental progress of each individual who is referred to these Specialized Therapeutic Services.

Specialized Therapeutic Services include:

1. Oral Health Services: Diagnostic, Prophylactic, Restorative, Oral Surgery
2. Services for Maladaptive Behaviors/Social-Emotional Behavior Impairments (MB/SEDI) Due

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

to/Associated with a Developmental Disability: Individual and group interventions and counseling
3. Physical Health Services: Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy, Diagnostic and Treatment, Physician Services, Nursing Services, Diabetes Self-Management

The need for a Specialized Therapeutic Service must be identified in the Individual Program Plan, also known as a Plan of Care, and is to be provided only when the individual's regional center planning team has:

1. Determined the reason why other generic or approved Medicaid State plan services can not/do not meet the unique oral health, behavioral/social-emotional health, physical health needs of the consumer as a result of his/her developmental disability and the impact of the developmental disability on the delivery of therapeutic services;
2. Determined that a provider with specialized expertise/knowledge in serving individuals with developmental disabilities is needed, i.e., a provider of Medicaid State Plan services does not have the appropriate qualifications to provide the service;
3. Determined that the individual's needs cannot be met by an approved Medicaid State plan provider delivering routine approved Medicaid State plan services;
4. Determined that the Specialized Therapeutic Service is a necessary component of the overall Plan of Care that is needed to avoid institutionalization; and
5. Consulted with a Regional Center clinician.

The need to continue the Specialized Therapeutic Service will be evaluated during the mandatory annual review of the individual's IPP in order to determine if utilization is appropriate and progress is being made as a result of the service being provided.

The following specify the differences between Specialized Therapeutic Services and services available under the approved Medicaid State Plan:

1. Provider qualifications.
2. The scope (what is provided).
3. The services will be offered either at the consumer's home, the program site, or when appropriate, the provider's site.

Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities, validation of which must be obtained by the regional center prior to vendorization and maintained in the regional center vendor file. This expanded qualification requirement differentiates providers of Specialized Therapeutic Services from approved Medicaid State plan providers. These providers include physicians/surgeons, nurse practitioners, registered nurses, licensed vocational nurses, psychologists, social workers, speech therapists, physical therapists, physical therapy assistants, dental hygienists, dentists, and marriage and family therapists. Certified occupational therapists, occupational therapy assistants, respiratory therapists, and chemical addiction counselors are also included.

Scope of Services: When provided as a home and community-based service, a Specialized Therapeutic Service may require one or more of the following if determined critical to the ongoing maintenance of the oral care, health care, or behavioral/social-emotional health care of the individuals in his/her residence or

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

program environment. This expansion of the scope of the Specialized Therapeutic Service differentiates it from other approved Medicaid State plan services. These are provided as a component of an allowable specialized therapeutic service and are designed to improve the consumer or caregiver's capacity to effectively access services, interpret care instructions, or provide care as directed by the clinical professional. Each of these will be provided only if it is directly associated with a specialized therapeutic service provided to an individual and are included in an approved plan of care.

1. Family support and counseling - Critical to a full understanding of the impact of involved developmental disabilities on the presenting health care need and effective treatment. The health care practitioner delivering the health, dental, or behavioral/social-emotional health specialized services may need to provide family support and/or counseling, as well as consumer training and consultation with other physicians or involved professionals, in order to ensure the proper understanding of the treatment and support in the person's home environment and that it is critical to effective treatment of people with developmental disabilities;
2. If cost-effective and necessary, the regional center may include the cost of travel in order to allow the provider to provide the care at a location that is necessary due to the disabilities of the individual;
3. Consultation with other involved professionals in meeting the physical, behavioral/social-emotional health and/or dental health needs of the consumer through specialized therapeutic services. This allows the clinical provider of specialized therapeutic services to properly involve other professional care givers who deliver services in accordance with the individual's plan of care;
4. Consumer training - at times the individual will require additional training by a specialized therapeutic service provider to maintain or enhance the long-term impact of the oral, behavioral/social-emotional health, or health care treatment provided. An appropriately licensed or certified provider, as defined above, will provide this training.

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):*
Dentist Dental Hygienist Psychologist Marriage and Family Therapist Social Worker Chemical Addiction Counselor Physician/Surgeon Speech Therapist	Business and Professions Code: Dentist: §1628-1635 Dental Hygienist: §1766 & 1768 Psychologist: §2940-2946	Chemical Addiction Counselor - certified in accordance with Title 9 CCR § 9846-13075 Physicians and Surgeons: Business and Professions	Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities.

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

Occupational Therapist Occupational Therapy Assistant Physical Therapist Physical Therapy Assistant Respiratory Therapist RN LVN Nurse Practitioner	Marriage & Family Therapist: §4986.2 Social Worker: §4996.1 – 4996.2 Physician/Surgeon: §2080-2096 Speech Therapist: §2532.1-2532.6 Occupational Therapist and Assistant: §2570.6 Physical Therapist: §2636.5 Physical Therapy Assistant: §2655 Respiratory Therapist: §3733-3737 RN § 2725-2742 LVN § 2859-2873.7 Nurse Practitioner: §2834-2837 As appropriate, a business license as required by the local jurisdiction where the business is located.	Code, §2080-2085	
Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):			

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
All Specialized Therapeutic Services 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.

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: **Transition Set Up Expenses**

Service Definition (Scope):

Transition/Set Up Expenses are one-time, non-recurring set-up expenses to assist individuals who are transitioning from an institution to their own home. These expenses fund some of the initial set-up costs that are associated with obtaining and securing an adequate living environment and address the individual's health and safety needs when he or she enters a new living environment.

"Own home" is defined as any dwelling, including a house, apartment, condominium, trailer, or other lodging that is owned, leased, or rented by the individual.

This service includes necessary furnishings, household items and services that an individual needs for successful transition to community living and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Moving expenses;
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy;
- Set up fees or non-refundable deposits for utilities (telephone, electricity, heating by gas);
- Essential furnishings to occupy and use a community domicile, such as a bed, table, chairs, window blinds, eating utensils, food preparation items, etc.

These services exclude:

- Items designed for diversionary/recreational/entertainment purposes, such as hobby supplies, television, cable TV access, or VCRs and DVDs.
- Room and board, monthly rental or mortgage expense, regular utility charges, household appliances, and food.

Items purchased through this service are the property of the individual receiving the service and the individual takes the property with him/her in the event of a move to another residence.

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

Some of these expenses may be incurred before the individual transitions from an institution to the community. In such cases, the Transition/Set Up expenses incurred while the person was institutionalized are not considered complete until the date the individual leaves the institution. Transition/Set Up expenses included in the individual's plan of care may be furnished up to 180 days prior to the individual's discharge from an institution. However, such expenses will not be considered complete until the date the individual leaves the institution and is determined eligible for 1915(i) State Plan Services.

In the event an individual dies before the relocation can occur, but after the expenses have been incurred, the State will claim FFP at the administrative rate for services which would have been necessary for relocation to have taken place.

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)*:
Public Utility Agency Retail and Merchandise Company Health and Safety agency Individual (landlord, property management) Moving Company	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	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 Transition/Set Up Providers	Regional centers, through the vendorization process, verify providers meet requirements/ qualifications outlined in Title 17, CCR, § 54310	Verified upon application for vendorization and ongoing thereafter through oversight and

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

	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.	monitoring activities.

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

☐	Participant-directed	☑	Provider managed

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

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.

☐	HCBS Case Management	
☐	HCBS Homemaker	
☐	HCBS Home Health Aide	
☐	HCBS Personal Care	
☐	HCBS Adult Day Health	
☐	HCBS Habilitation	
☐	HCBS Respite Care	
☑	Other Services	
	☑	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
	☑	HCBS Specialized Medical Equipment and Supplies
	☑	HCBS Specialized Therapeutic Services
	☑	HCBS Transition/Set-Up Expenses
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

REIMBURSEMENT METHODOLOGY FOR SPEECH, HEARING LANGUAGE SERVICES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective May 15, 2013 can be found at the following link: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR DENTAL SERVICES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective May 15, 2013 can be found at the following link: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR OPTOMETRIC/OPTICIAN SERVICES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective May 15, 2013 can be found at the following link: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION LENSES AND FRAMES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective May 15, 2013 can be found at the following link: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR PSYCHOLOGY SERVICES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective May 15, 2013 can be found at the following link: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR CHORE SERVICES

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

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

REIMBURSEMENT METHODOLOGY FOR COMMUNICATION AIDES

There are two methodologies to determine the monthly rate for this service.

1) **Usual and Customary Rate Methodology** - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) **Median Rate Methodology -** As described on page 70, above.

REIMBURSEMENT METHODOLOGY FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

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

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** - As described on page 70, above. If the provider does not have a usual and customary rate, then rates are set using #2 below.

2) **Median Rate Methodology -** As described on page 70, above.

3) **Rate based on Regional Center Employee Travel Reimbursement** – The maximum rate paid to individual transportation provider is established as the travel rate paid by the regional center to its own employees. This rate is used only for services provided by an individual transportation provider.

REIMBURSEMENT METHODOLOGY FOR NUTRITIONAL CONSULTATION

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

REIMBURSEMENT METHODOLOGY FOR SKILLED NURSING

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective May 15, 2013 can be found at the following link: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

DHCS Fee Schedules - As described on page 70, above. The fee schedule, effective May 15, 2013 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 page 70, above.

REIMBURSEMENT METHODOLOGY FOR TRANSITION/SET-UP EXPENSES

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