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State/Territory Name: California

State Plan Amendment (SPA) #: 24-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

February 1, 2024

Michelle Baass
Director and Interim State Medicaid Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: CA 24-0001 §1915(i) Home and Community-Based Services (HCBS) State Plan Amendment (SPA)

Dear Interim Director Baass:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its §1915(i) state plan home and community-based services (HCBS) benefit, transmittal number CA 24-0001. The effective date for this amendment is February 1, 2024. With this amendment, the state is expanding the needs-based criteria for children under five, adds Participant-Directed Services and related budget authority, and adds incentive payments to providers who assist individuals with obtaining competitive and integrated employment.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-i pages 1, 8, 9, 9a, 10, 11, 12, 16, 57, 59, 59a, 94, 95, 111g, 111h, 112, 113, 114, 115
- Attachment 4.19-b pages 78f, 78f-1, 78g

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of

Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Alice Hogan at Alice.Hogan@cms.hhs.gov or (404) 562-7432.

Sincerely,

[redacted]

Digitally signed by George P. Failla Jr -S
Date: 2024.02 01 15:19:32 -05'00'

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc: Cheryl Young, CMS
Deanna Clark, CMS
Blake Holt, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0001

2. STATE: CA

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

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

4. PROPOSED EFFECTIVE DATE
January 10, 2024

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023-24 $ 2,360,000
b. FFY 2024-25 $ 3,150,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i pages 1, 8, 9, 9a(new), 10, 11, 12, 16, 57, 59, 59a (new), 94,111g (new), 111h (new) 112, 113, 114, 115
Attachment 4.19-B pages 78f, 78f-1, 78g

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i: pages 1, 8, 9, 16, 10, 11, 12, 57, 59, 94, 112, 113, 114, 115
Attachment 4.19-B pages 78f, 78f-1, 78g

9. SUBJECT OF AMENDMENT
Modify needs-based eligibility. Addition of participant directed services, incentive payments for placement in competitive integrated employment.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Michelle Baass

13. TITLE
Interim State Medicaid Director

14. DATE SUBMITTED
January 9, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
January 9, 2024

17. DATE APPROVED
February 1, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
February 1, 2024

19. SIGNATURE OF APPROV [redacted]
Digitally signed by George P. Failla Jr -S
Date: 2024 02.01 15:19:08 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations & Oversight

22. REMARKS
Pen and ink changes authorized 1/30/2024, boxes 7 and 8 to read:

Box 7: Attachment 3.1-i pages 1, 8, 9, 9a (new), 10, 11, 12, 16, 57, 59, 59a (new), 94, 95, 111g (new), 111h (new), 112, 113, 114, 115
Attachment 4.19-b pages 78f, 78f-1, 78g

Box 8: Attachment 3.1-i pages 1, 8, 9, 10, 11, 12, 16, 57, 59, 94, 95, 112, 113, 114, 115
Attachment 4.19-b pages 78f, 78f-1, 78g

Instructions on Back

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

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

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

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

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

***Select one*:**

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

The individual meets the following need-based criteria:

1) Individuals over the age of five (5), must require assistance with at least three of the following areas of major life activity, as appropriate to the person's age:
   - Receptive and expressive language;
   - Learning;
   - Self-care;
   - Mobility;
   - Self-direction;
   - Capacity for independent living
   - Economic self-sufficiency

   Children zero (0) to four (4) years of age requiring assistance with at least two of the above listed areas of major life activity (does not apply to capacity for independent living, or economic sufficiency given the age of the person), are also eligible for 1915(i) services.
2) Without habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 et seq.), requires assistance with learning new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands; and
3) Demonstrates a likelihood of retaining new skills acquired through habilitation overtime.

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

State Plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The individual meets the following need-based criteria: 1) Individuals over the age of five (5), must require assistance with at least three of the following areas of major life activity, as appropriate to the person's age:	Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's order. The need must	The individual must be diagnosed with a developmental disability and a qualifying developmental deficit exists in either the self-help or social-emotional area.	The individual requires: • Continuous availability of facilities, services, equipment and medical and nursing personnel for prevention, diagnosis or

• Receptive and expressive language; • Learning; • Self-care; • Mobility; • Self-direction • Capacity for independent living • Economic self-sufficiency Children zero (0) to four (4) years of age requiring assistance with at least two of the above listed areas of major life activity (does not apply to capacity for independent living, or economic sufficiency given the age of the person), are also eligible for 1915(i) services. 2)Without habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 *et seq.*), requires assistance with learning new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands; and	be for a level of service which includes the continuous availability of procedures such as, but not limited to, the following: • Nursing assessment of the individuals' condition and skilled intervention when indicated: • Administration of injections and intravenous of subcutaneous infusions; • Gastric tube or gastronomy feedings; • Nasopharyngeal aspiration; • Insertion or replacement of catheters • Application of dressing involving prescribed medications;	For self-help, a qualifying developmental deficit is represented by two moderate or severe skill task impairments in eating, toileting, bladder control or dressing skill. For the social-emotional area, a qualifying developmental deficit is presented by two moderate or severe impairments from a combination of the following: social behavior, aggression, self-injurious behavior, smearing, destruction of property, running or wandering away or emotional outbursts.	treatment of acute illness or injury.

3) Demonstrates a likelihood of retaining new skills acquired through habilitation over time.	• Treatment of extensive decubiti; • Administration of medical gases		

*Long Term Care/Chronic Care Hospital
**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

In addition to the needs identified above, individuals over the age of five (5) must also have a diagnosis of a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code and Title 17, California Code of Regulations, §54000 and §54001 as follows:

Welfare and Institutions Code 4512. As used in this division:

(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation but shall not include other handicapping conditions that are solely physical in nature.

Title 17, CCR, §54000. Developmental Disability.

a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

b) The Developmental Disability shall:

1. Originate before age eighteen;
2. Be likely to continue indefinitely;
3. Constitute a substantial disability for the individual as defined in the article.

c) Developmental Disability shall not include handicapping conditions that are:

1. Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.
2. Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.
3. Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. Reasonable Indication of Need for Services. In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services.** The state requires (select one):	
	◉	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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.

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

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

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

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

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

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

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

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

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

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

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

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

If an individual receives both Prevocational and Supported Employment services, only the provider who assists them in obtaining CIE placement will be eligible for the incentive. The reimbursement for Supported Employment (Individual Services) provided to individuals working through an internship includes the following incentive payments:

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

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

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

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

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

☐	Categorically needy *(specify limits):*

Services are intended to develop and teach the following general skills that lead to competitive and integrated employment: the ability to communicate effectively with supervisors, co-workers and customers; generally accepted community work place conduct and dress; ability to follow directions; ability to attend to asks; work place problem solving skills and strategies; general work place safety and mobility training. Additionally, both work adjustment and supportive habilitation services as defined in Title 17 CCR § 58820 (c)(2), should allow for the development of productive skills, physical and psychomotor skills, interpersonal and communicative skills, health and hygiene maintenance, personal safety practices, self-advocacy training, and other skills aimed at maintaining a job and as outlined in the individual's person-centered services and supports plan. Individuals may be compensated based upon their performance and upon prevailing wage. However, compensation is not the sole purpose of participation in this service.

Prevocational services are designed to prepare individuals in non-job-task-specific strengths and skills that contribute towards obtaining a competitive and integrated employment, as opposed to vocational services whose sole purpose is to provide employment without habilitation goals geared towards skill building. Transportation services are not included under Prevocational Services.

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

1. A one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2. An additional one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3. An additional one-time payment made to a provider when an individual has been employed consecutively for one year.
4. After a provider assists four individuals to achieve competitive integrated employment (CIE) placement for at least 30 days, an additional payment is made to provider for each consumer thereafter who obtains CIE and is still employed:
    c. after 30 consecutive days.
    d. after six consecutive months.

If an individual receives both Prevocational and Supported Employment services, only the provider who assists them in obtaining CIE placement will be eligible for the incentive.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or payments that are passed through to users of supported employment services.

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

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

☐	Categorically needy *(specify limits):*
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

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

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

Service Title: Financial Management Services

Service Definition (Scope):

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

All FMS services shall:

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

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

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

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Financial Management Services Provider	Business license, as appropriate		

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 FMS providers	Regional centers, through the vendorization, 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: **Intensive Transition Services**

Service Definition (Scope)*:*

Intensive Transition Services (ITS) is a service providing support to those individuals who have been assessed to have complex behavioral health needs and who have transitioned into a community living option. Provision of Intensive Transition Services will begin once the individual has transitioned into the community setting. The IPP team determines if ITS would be of benefit to the consumer based on an individualized need of a more intensive service that would make the transition possible.

ITS provides a team that will work in a person-centered approach to create a network of resources that will eventually allow the individual to live independently in the community. Services are directly provided by the team members consisting of the following:

- Assessment – Initial and ongoing assessment to provide the below services in an individualized approach and continuously pivot based on the ongoing needs;
- Substance use recovery treatment;
- Anger management;
- Self-advocacy;
- Medication management;
- Health and dietary education;
- Sex education/fostering healthy relationships;
- Behavioral support and modification training for the individual - ITS engages with service providers and circle of support to provide consultative information on managing the
- consumers behavior if deemed appropriate and necessary to support the consumers transition; Outpatient therapy – counseling by professionals who specialize with intellectual/developmental disabilities crisis work;

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

Service Title: **Participant Directed Services**

Service Definition (Scope)*:*

Participant-Directed Services are services and activities not otherwise provided through this 1915(i) benefit or through the Medicaid state plan and are services and activities that improve and maintain the participant's opportunities for full inclusion in the community, and enable the development of social skills, independence, and personal relationships. Eligible services or activities must promote active participation in the community, address an identified need in the service plan, be documented in the participant's Individual Program Plan, and purchased from the participant's Individual Budget. Participant Directed Services meet the following requirements: the service or activity would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND the participant does not have the funds to purchase the service or activity, or the service or activity is not available through another source. Experimental or prohibited treatments are excluded. Services and activities that are primarily recreational and diversionary are excluded.

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

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

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

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

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Individual provider of services	As appropriate, a business license as required by the local jurisdiction where the business is located	N/A	As appropriate and/or required by law for provision of the service being provided.
Business entity provider of services	As appropriate, a business license as required by the local jurisdiction where the business is located	N/A	As appropriate and/or required by law for provision of the service being provided.

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 and Service Agency	FMS will verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter through the IPP process.
Business Entity	FMS will verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter through the IPP process.

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

Participant-Direction of Services

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

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

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

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

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

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

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

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

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

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

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

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

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

5. ☒ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:
   - Specifies the State Plan HCBS that the individual will be responsible for directing;
   - Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
   - Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
   - Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
   - Specifies the financial management supports to be provided.

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

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

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

7. Opportunities for Participant-Direction

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

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

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

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

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

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

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

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

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

2) Incentive payments will be paid to service providers. If an individual receives both Prevocational and Supported Employment services, only the provider who assists them in obtaining CIE placement will be eligible for the incentive. Incentive payments include 1) A one-time payment of $1,000 made to a single provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days. 2) An additional one-time payment of $1,250 made to a single provider when an individual obtains competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $1,500 made to a single provider when an individual has been employed consecutively for one year.

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

Effective for services provided on or after February 1, 2024, in addition, after a provider assists four individuals to achieve competitive integrated employment for at least 30 days, for each individual thereafter, an additional payment is made to a single provider consisting of:

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

Effective for services provided on or after February 1, 2024, for each individual who achieves competitive integrated employment after exiting an internship, incentive payments will be paid to a single provider consisting of:

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

Effective for services provided on or after February 1, 2024, incentive payments will be paid for internship programs, which are job readiness programs in integrated settings for the purposes of developing general strengths and skills that contribute to employability in paid employment in integrated community settings.

The incentive payments will be applied as follows:

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

3) Individual Providers (Participant Directed) – $30.54 per hour, effective for services provided on or after February 1, 2024.

REIMBURSEMENT METHODOLOGY FOR ENHANCED HABILITATION – PREVOCATIONAL SERVICES

There are two rate setting methodologies for this service:

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

2) Rates for Supported Employment Group providers were set in State statute, prior to April 1, 2022.

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

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

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

Incentive payments will be paid to service providers. If an individual receives both Prevocational and Supported Employment services, only the provider who assists them in obtaining CIE placement will be eligible for the incentive. Incentive payments include 1) A one-time payment of $1,000made to a single provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days. 2) An additional one-time payment of $1,250 made to a single provider when an individual obtains competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $1,500 made to a single provider when an individual has been employed consecutively for one year.

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

Effective for services provided on or after February 1, 2024, in addition, after a single provider assists four individuals to achieve competitive integrated employment for at least 30 days, for each individual thereafter, an additional payment is made to provider consisting of:

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

REIMBURSEMENT METHODOLOGY FOR TECHNOLOGY SERVICES

There are two rate setting methodologies for Technology Services:

1) A usual and customary rate – As described on page 71a of Attachment 4.19-B in the approved SPA. If the provider does not have a usual and customary rate, then rates are set using #2 below.
2) The median rate methodology – As described on pages 71a-73 of Attachment 4.19-B in the approved SPA.

REIMBURSEMENT METHODOLOGY FOR SELF-DIRECTED SUPPORT SERVICES

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

REIMBURSEMENT METHODOLOGY FOR COORDINATED FAMILY SUPPORTS

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The Coordinated Family Supports fee schedule rates are available at https://www.dds.ca.gov/wp-content/uploads/2023/01/CFS-Service-Code-076-rates-1.1.23ac.pdf and were set as of November 1, 2023, and are effective for services provided on or after that date.

REIMBURSEMENT METHODOLOGY FOR HOMEMAKER SERVICES

There are two rate methodologies to set hourly rates for Homemaker services provided by either an agency or individual.

1) Usual and Customary Rate Methodology - As described on page 71a, 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 pages 71a-73, above.