STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Reimbursement - Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.
In California, many primary care services are billed using local codes. For the purpose of reimbursement under 42 CFR 447.405, these local codes correspond to appropriate national E&M, vaccine and CPT-4 codes as indicated in the crosswalks found in Supplements 19, 20 and 21 to Attachment 4.19-B.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.
The Department will be using the Los Angeles, CA (Locality 18) Medicare rate for all Los Angeles County's.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: ____________________

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

2) **Median Rate Methodology -** As described on pages 71-73, above, with the exception that the SB 81 rate increase does not apply for the provider types under B above.

C. Mobility Related Day Services – The providers in this subcategory are Driver Trainer, Mobility Training Services Agency and Mobility Training Services Specialist. There are two rate setting methodologies for providers in this subcategory.

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

REIMBURSEMENT METHODOLOGY FOR HABILITATION -- BEHAVIORAL INTERVENTION SERVICES

This service is comprised of the following two subcomponents:

A. Non-Facility-Based Behavior Intervention Services– Providers and services in this subcategory are Behavior Analysts, Associate Behavior Analysts, Behavior Management Assistants, Behavior Management Intervention Training, Parent Support Services, Individual/Family Training Providers, Family Counselors, and Behavioral Technicians, Educational Psychologists, Clinical Social Workers, and Professional Clinical Counselors. There are two rate setting methodologies to determine the hourly rates for all providers in this subcategory (except psychiatrists, physicians and surgeons, physical therapists, occupational therapists, psychologists, Marriage and Family Therapists (MFT), speech pathologists, and audiologists -see DHCS Fee Schedule below).

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

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

B. Crisis Intervention Facility – The following five methodologies apply to determine the daily rates for these providers;

1) **Usual and Customary Rate Methodology -** As described on page 71, 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 71-73, above, with the exception that the SB 81 rate increase does not apply for Crisis Intervention Facilities.

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

a) *the facility component*: the allowable costs used to calculate the facility component include payroll costs of facility staff and facility related costs such as lease, facility maintenance, repairs, cable/internet, etc.

b) *the individualized services and supports component*: the allowable costs used to calculate the individualized services and supports component include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports and other consumer specific program costs, and

c) *the transition plan component*: the allowable costs used to calculate the transition component includes the salaries, wages, payroll taxes and benefits of direct care staff providing additional services and supports needed to support a consumer during times of transition out of the CCH.

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

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

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

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

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

4) Community Crisis Homes (State-Operated) Rate Methodology –

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

Specific Components:

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

Claim amount per individual: Each facility compiles daily attendance for each individual which the state receives in whole at the conclusion of each month. Utilizing daily attendance information in conjunction with the calculation of allowable costs described above (the interim rate), the state utilizes the daily attendance to assign an allocation per bed for each day it is occupied. The allowable costs are divided by the number of bed occupancy days, resulting in the allocated amount per individual per day for each home minus non-allowable costs. Only costs associated with Medi-Cal eligible individuals are submitted for reimbursement. Allocation of costs consists of the following:

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

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

Unallowable costs are captured in the same format via the statewide accounting system. Allocation of such costs consists of the following:

Lease or mortgage for facility and/or facility grounds; facility maintenance and repairs, utilities, food; furniture, and laundry equipment, transportation, and information technology services that do not meet the primary cost objective.

Reconciliation:

The state reviews submitted costs for the past fiscal year and determines the facility-specific costs for that year (minus any unallowable costs) based on the same cost components described above for the interim rate. After the facility-specific costs are established, claims for federal reimbursement are reconciled based on the actual cost of delivering the service. Federal claims are submitted if the final costs are higher than the interim rate or reimbursed to CMS if the final cost is lower than the interim rate. The state is responsible for reimbursing CMS for all FFP overpayments identified.

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

New homes:

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

5) Mobile Crisis Team (State-Operated) Rate Methodology

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

Specific Components:

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

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

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

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

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

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

REIMBURSEMENT METHODOLOGY FOR RESPITE CARE

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

1) **Rates Set pursuant to a Cost Statement Methodology –** As described on pages 70-71, above. This methodology is used to determine the hourly rate for In-home Respite Agencies. Rates in effect as of October 1, 2021 are available at the following link: https://www.dds.ca.gov/wp-content/uploads/2021/09/CBDP_IHRA_Rates_eff_10_1_21.pdf

2) **Rates set in State Regulation –** This rate applies to individual respite providers. The rate for this service is $19.18 per hour. This rate is based on the current California minimum wage of $14.00 per hour, effective January 1, 2021, plus $.81 differential (retention incentive), plus mandated employer costs of 20.82 %, plus $1.29 for SB 81 increase.

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

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

4) **Usual and Customary Rate Methodology -** As described on page 71, above. This methodology is applicable for the following providers (unit of service in parentheses); Adult Day Care Facility (daily), Camping Services (daily) providers. If the provider does not have a usual and customary rate, then rates are set using #5 below.

5) **Median Rate Methodology -** As described on pages 71-73, above.

REIMBURSEMENT METHODOLOGY FOR ENHANCED HABILITATION – SUPPORTED EMPLOYMENT (INDIVIDUAL)

There are two rate setting methodologies for this service:

1) Supported employment rates for all providers are set in State statute at $39.35 per job coach hour. The rate schedule, in effect as of October 1, 2021, can be found at the following link: https://www.dds.ca.gov/wp-content/uploads/2021/07/WAP_SEP_Rates_Eff_10_1_21.pdf

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%.

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

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

REIMBURSEMENT METHODOLOGY FOR ENHANCED HABILITATION – PREVOCATIONAL SERVICES

There are three rate setting methodologies for this service:

1) Daily rates for Work Activity Program providers are set using the cost statement methodology, as described on pages 70-71, with the exception that the SB 81 rate increase does not apply. The Work Activity Program rate schedule can be found at the following link. The rate schedule is effective July 1, 2016. https://www.dds.ca.gov/wp-content/uploads/2021/07/WAP_SEP_Rates_Eff_10_1_21.pdf.

2) Rates for Supported Employment Group providers are set in State statute at $36.57 per job coach hour.

The rate schedule, in effect as of October 1, 2021, can be found at the following link:
https://www.dds.ca.gov/wp-content/uploads/2021/07/WAP_SEP_Rates_Eff_10_1_21.pdf.

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

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

competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $3,000 made to a provider when an individual has been employed consecutively for one year.

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 71, 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 71-73, above.

REIMBURSEMENT METHODOLOGY FOR HOME HEALTH AIDE SERVICES

DHCS Fee Schedules - As described on page 71, above. The fee schedule rates for Home Health Aide Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR COMMUNITY BASED ADULT SERVICES

DHCS Fee Schedules - As described on page 71, above. The fee schedule rates for Community Based Adult Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR PERSONAL EMERGENCY RESPONSE SYSTEMS

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

1) **Usual and Customary Rate methodology** - As described on page 71, 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 71-73, above, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology.

REIMBURSEMENT METHODOLOGY FOR VEHICLE MODIFICATION AND ADAPTATION

The per modification rate for vehicle modifications is determined utilizing the usual and customary rate methodology, as described on page 71, above.

REIMBURSEMENT METHODOLOGY FOR SPEECH, HEARING LANGUAGE SERVICES

There are two rate setting methodologies for this service:

1) **DHCS Fee Schedules** - As described on page 71, above. The fee schedule rates for Speech, Hearing Language Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) Median Rate Methodology – the median rate (as defined previously) may be used if the provider has at least one year experience working with persons with developmental disabilities, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology.

REIMBURSEMENT METHODOLOGY FOR DENTAL SERVICES

There are two rate setting methodologies for this service:

1) **DHCS Fee Schedules** - As described on page 71, above. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) **Median Rate Methodology** – the median rate (as defined previously) may be used if the provider has at least one year experience working with persons with developmental disabilities, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology.

REIMBURSEMENT METHODOLOGY FOR OPTOMETRIC/OPTICIAN SERVICES

DHCS Fee Schedules - As described on page 71, above. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION LENSES AND FRAMES

DHCS Fee Schedules - As described on page 71, above. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR PSYCHOLOGY SERVICES

There are two rate setting methodologies for this service:

1) **DHCS Fee Schedules** - As described on page 71, above. The fee schedule rates for Psychology Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) Median Rate Methodology – the median rate (as defined previously) may be used if the provider has at least one year experience working with persons with developmental disabilities, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology.

REIMBURSEMENT METHODOLOGY FOR CHORE SERVICES

Usual and Customary Rate Methodology - As described on page 71, above.

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 71, 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 71-73, above, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology.

REIMBURSEMENT METHODOLOGY FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Usual and Customary Rate Methodology - As described on page 71, 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 71, 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 71-73, above.

3) **Rate based on Regional Center Employee Travel Reimbursement** – The maximum rate paid to an individual transportation provider is established as the travel rate paid by the regional center to its own employees at the IRS standard mileage rate. 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 71, above.

REIMBURSEMENT METHODOLOGY FOR SKILLED NURSING

DHCS Fee Schedules - As described on page 71, above. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

DHCS Fee Schedules - As described on page 71, above. The fee schedule, effective October 1, 2021 can be found at the following link: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

REIMBURSEMENT METHODOLOGY FOR TRANSITION/SET-UP EXPENSES

Usual and Customary Rate Methodology - As described on page 71, above.

REIMBURSEMENT METHODOLOGY FOR COMMUNITY-BASED TRAINING SERVICES

The maximum rate for this service is set in State statute at $16.22 per hour.

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 Community-Based Training Services includes an increase of 8.2%.

REIMBURSEMENT METHODOLOGY FOR FINANCIAL MANAGEMENT SERVICES

Rates for FMS are set in State regulation as follows:

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

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

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

REIMBURSEMENT METHODOLOGY FOR INTENSIVE TRANSITION SERVICES

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

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

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

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

The state assures that it will only begin seeking Federal Financial Participation for ITS once an individual is eligible to receive the service.

REIMBURSEMENT METHODOLOGY FOR HOUSING ACCESS SERVICES

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

REIMBURSEMENT METHODOLOGY FOR FAMILY SUPPORT SERVICES

There are two rate setting methodologies for this service. If the provider does not have a "usual and customary," then the maximum rate is set using the median rate setting methodology. Usual and customary and median rates (with the exception that the SB 81 rate increase does not apply) are defined previously.

REIMBURSEMENT METHODOLOGY FOR OCCUPATIONAL THERAPY

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

1) **DHCS Fee Schedules** - As described on page 71, above. The fee schedule rates for Occupational Therapy Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) **Median Rate Methodology** – As described on pages 71-73, above, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology. This rate may be utilized if the provider has at least one year of experience working with persons with developmental disabilities.

REIMBURSEMENT METHODOLOGY FOR PHYSICAL THERAPY

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

1) **DHCS Fee Schedules** - As described on page 71, above. The fee schedule rates for Physical Therapy Services were set as of October 1, 2021 and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx as well as https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

2) **Median Rate Methodology** – As described on pages 71-73, above, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology. This rate may be utilized if the provider has at least one year of experience working with persons with developmental disabilities.

REIMBURSEMENT METHODOLOGY FOR FAMILY/ CONSUMER TRAINING

The median rate methodology, as described on pages 71-73 above, with the exception that the SB 81 rate increase does not apply for this provider type under this methodology, is used to determine the hourly rates for providers in this subcategory.

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Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

90749, 99217-99220, 99224-99226, 99234 -99236, 99288, 99318, 99339, 99340, 99358, 99359, 99363, 99364, 99374, 99375, 99377-99380, 99386, 99387, 99396, 99397, 99402-99404, 99406-99409, 99411, 99412, 99420, 99429, 99441-99444, 99450, 99455, 99456, 99463, 99485-99489, 99495, 99496, 99499.

☐ The State will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☐ State regional maximum administration fee set by the Vaccines for Children program

☒ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: .

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: Non-VFC $4.46 and VFC $9.00 .

Documentation of Vaccine Administration Rates in Effect 7/1/09 (Continued)

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, to December 31, 2014.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January