

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



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

October 11, 2017

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

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) CA 17-026, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 20, 2017. This amendment makes minor technical revisions to correct item numbering and to update terminology in the personal care services section of the state plan.

The effective date of this SPA is July 1, 2017. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-A, page 11
- Attachment 3.1-B, page 9
- Limitations on Attachment 3.1-A, page 30
- Limitations on Attachment 3.1-B, page 29

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

/s/

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

cc: Cynthia Owens, California Department of Health Care Services (DHCS)
Jim Elliott, DHCS
Wendy Ly, DHCS
Nathaniel Emery, DHCS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: SPA 17-026	2. STATE CA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE July 1, 2017
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION: SSA 1905(a)(24) 42 CFR 440.167	7. FEDERAL BUDGET IMPACT: a. FFY 2017 \$0 b. FFY 2018 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Limitations on Attachment 3.1-A, Page 30 Limitations on Attachment 3.1-B, Page 29 Attachment 3.1-A, Page 11 Attachment 3.1-B, Page 9	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Limitations on Attachment 3.1-A, Page 30 Limitations on Attachment 3.1-B, Page 29 Attachment 3.1-A, Page 11 Attachment 3.1-B, Page 9

10. SUBJECT OF AMENDMENT:

SPA 17-026 is a technical amendment to update the numbering of the personal care services section. It also updates Attachment 3.1 A and B pages with the term "developmentally disabled" instead of "mentally retarded."

11. GOVERNOR'S REVIEW (*Check One*):

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

ORIGINAL SIGNED

**Chief Deputy Director
Health Care Programs
State Medicaid Director**

16. RETURN TO:

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

15. DATE SUBMITTED:
July 20, 2017

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 20, 2017	18. DATE APPROVED: October 11, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Henrietta Sam-Louie	22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations

23. REMARKS:

10/5/17: CMS made pen and ink changes to Box 6 to add regulatory citation and to Box 15 to add submission date. CA approved changes via email dated 10/5/17.

State: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals.

Provided Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or at work.

Provided: State Approved (Not Physician) Service Plan Allowed

Service outside the Home Also Allowed

Limitations Described on Attachment

Not provided.

* Description provided on attachment

TN No. 17-026
Supersedes
TN No. 02-021

Approval date: October 11, 2017

Effective date: July 1, 2017

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S)

23. Any other medical care and other type of remedial care recognized under State law, specified by the Secretary.

g. Local Education Agency (LEA) Services

Provided: No Limitations With Limitations*
 Not Provided

24. Home and Community Care for Functionally Disabled Elderly Individuals.

Provided Not provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or at work.

Provided: State Approved (Not Physician) Service Plan Allowed
 Service Outside the Home Also Allowed
 Limitations Described on Attachment
 Not provided.

* Description provided on attachment

STATE PLAN CHART

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
26. Personal Care Services	<p>Personal care services authorized by the county worker are based on an assessment of the recipient. Qualified providers shall perform services in the recipient's home or at place of employment. Services may include one or more activities, such as assisting with the administration of medications, providing needed assistance, or supervision of basic personal hygiene, eating, grooming and toileting. Other incidental services may also be provided as long as they are subordinate to personal care services.</p>	<p>Personal care services shall be available to all categorically needy eligibles covered under the state plan and in accordance with state law. Services will be provided to the recipients who have an illness that has been diagnosed to be chronic and/or permanent (lasting at least one year) and who are unable to remain safely at home or are unable to obtain, retain or return to work without this assistance. Personal care service hours shall be capped at a maximum of 283 hours per month. Service hours for recipients shall be based on medical necessity as determined by the Statewide Uniform Assessment. Services in support of work are only available to the extent that service hours utilized at work are included in the total personal care service hours authorized for the recipient based on the recipient's need for services in the home. Authorized personal care services utilized by a recipient for work shall be services that are relevant and necessary in supporting and maintaining employment and shall not supplant any reasonable accommodation required of an employer under the Americans with Disabilities Act or other legal entitlements or third-party obligations. Services shall not be available to residents of a facility licensed by the California Department of Public Health nor to residents of a community care facility or a residential care facility licensed by the Department of Social Services Community Care Licensing Division.</p>

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

STATE PLAN CHART

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
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