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: 20 — 0036

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

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

4. PROPOSED EFFECTIVE DATE: October 1, 2020

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: 42 CFR 440.70

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 0
b. FFY 2022 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-L, pages 1-57

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-L, pages 1-57

10. SUBJECT OF AMENDMENT

Allow NPs, CNS's, and PA's to order home health services, including durable medical equipment and medical supplies, within their scope of practice.

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Jacey Cooper

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: October 12, 2020

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: **California**

Transmittal Number: **CA-20-0036**

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

CA SPA 20-0036

Description:

Allow NPs, CNS's, and PA's to order home health services, including durable medical equipment and medical supplies, within their scope of practice.

☑ Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

Date public notice was issued 09/01/2020 *(mm/dd/yyyy)*

☐ The state/territory assures that it has provided the public with advance notice of the amendment and reasonable opportunity to comment.

☐ The state/territory assures that it has included in the notice a description of the method for assuring compliance with 42CFR 440.345 related to full access to EPSDT services.

☐ The state/territory assures that it has included in the notice a description of the method for complying with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009.

☐ The state/territory assures that it has performed any required tribal consultation.

Upload Public Notice Documents	
Please provide a short description of this public notice: Copy of SPA 20-0036 Public Notice	
Uploaded Document Name:	**Date Uploaded:**
SPA_20-0035_and_20-0036_Public_Notice.pdf	

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

◉ **The population group for this Alternative Benefit Plan includes <u>only</u>** the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*

○ **The population group for this Alternative Benefit Plan includes the adult group under section 1902 (a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*

○ **The population for this Alternative Benefit Plan does not include the adult group under section 1902 (a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

☐ Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **<u>benchmark</u>** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

0

0

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: **California**

Transmittal Number: **CA-20-0036**

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	0
ABP2c	Enrollment Assurances - Mandatory Participants	0
ABP3	ABP3-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only if ABP has an effective date prior to 1/1/2020 or if only changing the section 1937 Coverage Option of an ABP implemented prior to 1/1/2020) or ABP3.1-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only for ABP's effective on or after 1/1/2020)	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form: ABP1 form **Uploaded Form Name:** **Date Uploaded:** ABP1.pdf

Form

Support Documents

Document

Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a Forms List

Form
Please provide a short description of this ABP2a form: ABP2a form **Uploaded Form Name:** **Date Uploaded:** ABP2a.pdf

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form

Support Documents

Document

Form ABP3: ABP3-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only if ABP has an effective date prior to 1/1/2020 or if only changing the section 1937 Coverage Option of an ABP implemented prior to 1/1/2020). Or ABP3.1-Selection of Benchmark Benefit Package or

Benchmark-Equivalent Benefit Package (Use only for ABP's effective on or after 1/1/2020).

ABP3 Forms List

Form
Please provide a short description of this ABP3 form: ABP3.1 form **Uploaded Form Name:** **Date Uploaded:** ABP3.1.pdf

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form
Please provide a short description of this ABP4 form: ABP4 form **Uploaded Form Name:** **Date Uploaded:** ABP4.pdf

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form
Please provide a short description of this ABP5 form: ABP5 form **Uploaded Form Name:** **Date Uploaded:** SPA_20-0036_ABP_05.pdf

Support Documents

Document

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form
Please provide a short description of this ABP7 form: ABP7 form **Uploaded Form Name:** **Date Uploaded:** ABP7.pdf

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form
Please provide a short description of this ABP8 form: ABP8 form **Uploaded Form Name:** **Date Uploaded:** ABP8.pdf

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form
Please provide a short description of this ABP9 form: ABP9 form **Uploaded Form Name:** **Date Uploaded:** ABP9.pdf

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form
Please provide a short description of this ABP10 form: ABP10 form **Uploaded Form Name:** **Date Uploaded:** ABP10.pdf

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form
Please provide a short description of this ABP11 form: ABP11 form **Uploaded Form Name:** **Date Uploaded:** ABP11.pdf

Support Documents

Document

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: **California**

Transmittal Number: **CA-20-0036**

☐ **One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.**

☑ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. ***States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:***

☑ **Indian Tribes**

Indian Tribes
Name of Indian Tribe:
DHCS Indian Tribes List
Date of consultation:
08/31/2020 *(mm/dd/yyyy)*
Method/Location of consultation:
DHCS Tribal Webinar/Teleconference

☐ **Indian Health Programs**

Indian Health Programs
Name of Indian Health Programs:
DHCS Indian Health Programs List
Date of consultation:
08/31/2020 *(mm/dd/yyyy)*
Method/Location of consultation:
DHCS Tribal Webinar/Teleconference

☐ **Urban Indian Organization**

Urban Indian Organizations
Name of Urban Indian Organization:
DHCS Urban Indian Organization List
Date of consultation:
08/31/2020 *(mm/dd/yyyy)*
Method/Location of consultation:
DHCS Tribal Webinar/Teleconference

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Document	
Please provide a short description of this support document: SPA 20-0036 Tribal Notice **Uploaded Document Name:**	**Date Uploaded:**
SPA_20-0035_and_20-0036_Tribal_Notice.pdf	
Please provide a short description of this support document: DHCS Tribal and Designees of Indian Health Programs List **Uploaded Document Name:**	**Date Uploaded:**
DHCS Tribal and Designees of Indian Health Programs Notification List for 2019-2	

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **California**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

CA-20-0036

Proposed Effective Date

10/01/2020 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 440.70

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2021	$ 0.00
Second Year	2022	$ 0.00

Subject of Amendment

Allow NPs, CNS's, and PA's to order home health services, including durable medical equipment and medical supplies, within their scope of practice.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  The Governor's Office does not wish to review the State Plan Amendment.

Signature of State Agency Official

Submitted By:	**Angeli Lee**
Last Revision Date:	**Oct 12, 2020**
Submit Date:	**Oct 12, 2020**