DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

OCT 13 2011

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor
MS: 0000
Sacramento, CA 95814

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) Number 11-019, which authorizes all certified nurse practitioners (CNPs) to bill Medicaid independently and, in those cases, the Department of Healthcare Services will pay the CNP independently. The SPA is effective July 1, 2011.

Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- **Limitations on Attachment 3.1-A, pg 12a**
- **Limitations on Attachment 3.1-A, pg 12b**
- **Limitations on Attachment 3.1-B, pg 12a**
- **Limitations on Attachment 3.1-B, pg 12b**
- **Attachment 3.1-A, pg 8a**
- **Attachment 3.1-B, pg 7**
- **Limitations on Attachment 3.1-A, Pg 24a**
- **Limitations on Attachment 3.1-B, pg 24**

If you have any questions, please contact Carolyn Kenline at (415) 744-3591 or at carolyn.kenline@cms.hhs.gov.

Sincerely,

Original Signed

Gloria Nagle, Ph.D., M.P.A.
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-019**

2. STATE: California

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2011

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 U.S.C. 1396d(a)(6), 42 CFR Sections 440.60 and 441.22

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2011-12~~ 2012 $ None
b. FFY ~~2012-13~~ 2013 $ None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, page 8a
Attachment 3.1-B, page 7
Limitations on Attachment 3.1-A, page 24a, page 12a, and page 12b
Limitations on Attachment 3.1-B, page 24, page 12a, and page 12b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A, page 8a, ~~TN 93-015~~
Attachment 3.1-B, page 7, ~~TN 95-006~~
Limitations on Attachment 3.1-B, page 24, ~~TN 93-015~~
Limitations on Attachment 3.1-A, page 12a
Limitations on Attachment 3.1-B, page 12a

10. SUBJECT OF AMENDMENT:

Expand coverage of nurse practitioner services to authorize all certified nurse practitioners to bill Medi-Cal independently pursuant to State legislation.

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

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

Original Signed

Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: JUL 18 2011

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 18, 2011

18. DATE APPROVED: OCT 13 2011

PLAN APPROVED – ONE

Original Signed

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 20

21. TYPED NAME: Gloria Nagle

22. TITLE: Associate Regional Administrator

23. REMARKS: Pen and ink changes to boxes 7, 8, and 9 were approved on September 30th .

FORM HCFA-179 (07-92)

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d4	Certified Nurse Practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.60.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7.	Home Health Services Home health agency services including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.	Home health services are covered if furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician as part of a written plan of care that the physician reviews every 60 days. Home health services include the following services: 1. Skilled nursing services as provided by a nurse licensed by the state 2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110. 3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110 4. Speech therapy services as provided by a speech therapist or speech pathologist licensed by the state and in accordance with 42 CFR 440.110. 5. Home health aide services provided by a Home Health Agency Medical supplies, equipment, and appliances suitable for use in the home.	
7a. 7b.	Home health nursing and aide services	Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/MR. Services must be medically necessary.	One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.

*Prior authorization is not required for emergency services
**Coverage is limited medically necessary services.

STATE PLAN CHART

(This chart is an overview only) Limitations on Attachment 3.1-B

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d4	Certified Nurse Practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.60.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

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7a. 7b.	Home health nursing and aide services	Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/MR. Services must be medically necessary.	One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.

*Prior authorization is not required for emergency services
**Coverage is limited medically necessary services.

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
TO THE MEDICALLY NEED GROUP(S): _____

19. Case management services and Tuberculosis related activities

a. Case management services as defined in, and to the group specified in, Supplemental 1 to ATTACHMENT 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lanterman), and Supplements 1a-1h to ATTACHMENT 3.1-A for County-Funded Case Management Services (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations* ____ Not provided

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

X Provided: X With Limitations* ____ Not provided

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Provided: + _____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided: + _____ Additional coverage ++ ____ Not provided

21. Certified pediatric or family nurse practitioners' services.

X Provided: _____ No Limitation X With limitations*
_____ No provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services of services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

	TYPE OF SERVICES	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	Extended services for pregnant women.	Preventive Services provided in the home, by Comprehensive Perinatal Services Providers, which are clinics and hospital outpatient departments, as medically necessary for pregnancy-related conditions only. Services are covered throughout pregnancy and through the end of the month in which the 60th day period following termination of pregnancy ends.	Prior authorization is required when services are provided in excess of the basic allowances. Basic allowances are described in Title 22, Sections 51348 and 51504.
21	Certified pediatric or family nurse practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.166.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

State/Territory: California

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

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in Accordance with section1920 of the Act).

X Provided: ____ No Limitations X With limitations*
Not provided.

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

Provided: ____ No Limitations ____ With limitations*
X Not provided.

23. Certified pediatric or family nurse practitioners' services.
Provided: ____ No Limitations X With limitations*

* Description provided on attachment.

	TYPE OF SERVICES	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
23	Certified pediatric or family nurse practitioners' services	All services permitted under scope of practice. As medically necessary, subject to limitations; however, experimental services are not covered. All limitations under 5a apply. All CNPs meet Federal provider qualifications as set forth in 42 CFR Part 440.166.	Limited to services provided to the extent permitted by applicable professional licensing statutes and regulations. Each patient must be informed that he/she may be treated by a CNP, prior to receiving services. Services ordered by a CNP, as permitted by State statutes and regulations, are covered to the same extent as if ordered by a physician. Prior authorization is not required, except as noted for physician services under 5a.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.