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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

November 12, 2020

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

Dear Ms. Cooper:

Enclosed is an approved copy of California State Plan Amendment (SPA) 20-0035, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on October 12, 2020. This SPA will allow nurse practitioners, clinical nurse specialists and physician assistants to order home health services, including durable medical equipment and medical supplies, within their scope of practice.

The effective date of this SPA is October 1, 2020 as requested. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Limitations on Attachment 3.1-A, pages 12b, 13, 14 and 14a
- Limitations on Attachment 3.1-B, pages 12b, 13, 14 and 14a

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

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2020.11.12 15:26:34 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Rene Mollow, Department of Health Care Services (DHCS)
Cynthia Smiley, DHCS
Jim Elliott, DHCS
Raquel Sanchez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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 — 0035

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: Limitations on Attachment 3.1A and 3.1B, pages 12b, 13, 14, 14a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Limitations on Attachment 3.1A and 3.1B, pages 12b, 13, 14

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: October 12, 2020

18. DATE APPROVED: November 12, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2020.11.12 15:27:08 -06'00'

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

23. REMARKS

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

FORM CMS-179 (07/92)

Instructions on Back

(Note: This chart is an overview only)

TYPE OF SERVICE	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 after a face-to-face encounter with a physician, nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA) or a certified nurse midwife, in accordance with 42 CFR 440.70, when furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician, NP, CNS, or PA as part of a written plan of care that the ordering practitioner 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 stated in accordance with 42 CFR 440.110. 3. Occupational therapy services as provide 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.	

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

(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7a. Home health nursing and 7b. Home health aide services	Medical supplies, equipment, and appliances suitable for use in any setting in which normal activities take place. Services are provided at a participant's residence, which does not include a hospital, nursing facility or ICF/IID. 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. All additional services and evaluations require prior authorization.
7c.1 Medical supplies	As prescribed by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant within the scope of his/her practice. Common household items, supplies not primarily medical in nature, and articles of clothing are not covered. Medical supplies provided in renal dialysis centers are included in the all-inclusive rate and are not separately billable. Medical supplies commonly used in providing SNF and ICF level of care are not separately billable.	Prior authorization is required for certain items and for items not used for the conditions specified in the Medical Supplies Formulary.

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(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1 Medical supplies (cont.)	Blood and blood derivatives are covered when ordered by a physician or dentist.	Prior authorization is not required. Certification that voluntary blood donations cannot be obtained is required from blood banks supplying the blood or facility where transfusion is given.
7c.2 Durable medical equipment	Covered after a face-to-face encounter with a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or a physician assistant (PA) when prescribed by a physician, NP, CNS, or PA and reviewed annually by the prescribing practitioner, in accordance with 42 CFR 440.70. DME commonly used in providing SNF and ICF level of care is not separately billable, Common household items are not covered.	Prior authorization is required when the purchase exceeds $100. Prior authorization is required when price, repairs, maintenance, or cumulative rental of listed items exceeds $250, except that the provision of more than two “H” oxygen tanks in any one month requires prior authorization. Purchase of rental of “By Report” (unlisted) items are subject to prior authorization regardless of purchase price. Authorization shall be granted only for the lowest cost item that meets medical needs of the patient.
7c.3 Hearing aids	Refer to Type of Service “12c Prosthetic and orthotic appliances, and hearing aids.”	Refer to Type of Service “12c Prosthetic and orthotic appliances, and hearing aids.

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(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.3 Enteral Formulae	Covered only when supplied by a pharmacy provider upon the prescription of a physician within the scope of his or her practice. Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable. Common household items (food) are not covered.	Prior authorization is required for all products. Authorization is given when the enteral formulae is used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. Dietary supplements or products that cannot be used as a complete source of nutrition are considered non-benefits, except that the program may deem such a product a benefit when it determines that the use of the product is neither investigational nor experimental when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions.

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