

## **Table of Contents**

**State/Territory Name: California**

**State Plan Amendment (SPA) #: 22-0037**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages



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July 22, 2022

Jacey Cooper  
Chief Deputy Director, Health Care Programs  
California Department of Health Care Services  
P.O. Box 997413, MS 0000  
Sacramento, CA 94899-7413

Re: California State Plan Amendment (SPA) 22-0037

Dear Ms. Cooper:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 22-0037. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during

the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of California also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) to waive the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

These waivers or modifications of the requirements related to SPA submission timelines and public notice apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that California's Medicaid SPA Transmittal Number 22-0037 is approved effective March 1, 2020. This SPA is in addition to all previous approved Disaster Relief SPAs, and does not supersede anything approved in those SPAs.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Cheryl Young at 415-744-3598 or by email at [Cheryl.Young@cms.hhs.gov](mailto:Cheryl.Young@cms.hhs.gov) if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of California and the health care community.

Sincerely,

A solid black rectangular box redacting the signature of the sender.

Alissa Mooney DeBoy  
On Behalf of Anne Marie Costello, Deputy Director  
Center for Medicaid and CHIP Services

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 2 — 0 0 3 7

2. STATE

CA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX  XXI

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

September 1, 2020 March 1, 2020

5. FEDERAL STATUTE/REGULATION CITATION

1915i of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2020 \$ 0  
b. FFY 2021 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 7.4 pages 90999999-90999999 91-102

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

None

9. SUBJECT OF AMENDMENT

Temporary 1915i service scope modifications and billing process changes for select services.

10. 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:

Please note: The Governor's Office does not wish to review the State Plan Amendment.

11. SIGNATURE OF STATE AGENCY OFFICIAL

Jacey Cooper

13. TITLE  
State Medicaid Director

14. DATE SUBMITTED  
April 25, 2022

15. RETURN TO

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

April 25, 2022

July 22, 2022

March 1, 2020

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S  
Date: 2022.07.22 07:47:33 -0400

Alissa Mooney Deboy

On behalf of Anne Marie Costello, Deputy Director, CMCS

Box 4: CMS pen and ink change to reflect earliest effective date for SPA provisions made per CMS guidance with state concurrence in informal comments dated 7/14/22.

Box 7: CMS pen and ink change to revise page numbering per state concurrence made in email dated 7/18/22.

## Section 7 – General Provisions

### 7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

*The state seeks to implement the changes to the state plan below effective September 1, 2020 through the end of the Public Health Emergency (PHE). The exception is the effective date of March 1, 2020, which applies only to Section D, Item 5, Telehealth, to the 1915(i) services described in that section of this SPA. This telehealth provision and effective date is in addition to all previously approved California Disaster Relief SPAs and does not supersede any telehealth provisions approved in earlier California Disaster Relief SPAs.*

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

#### Request for Waivers under Section 1135

  X   The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.   X   SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

- b.   X   Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- c.        Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in California Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*

**Section A – Eligibility**

- 1.        The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

- 2.        The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a.        All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b.        Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 3.        The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

Less restrictive resource methodologies:

4. \_\_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
  
5. \_\_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. \_\_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

1. \_\_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2. \_\_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

3. \_\_\_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4. \_\_\_\_\_ The agency adopts a total of \_\_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. \_\_\_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. \_\_\_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. \_\_\_\_\_ The agency uses a simplified paper application.
  - b. \_\_\_\_\_ The agency uses a simplified online application.
  - c. \_\_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### **Section C – Premiums and Cost Sharing**

1. \_\_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

2. \_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:
- a. \_\_\_\_ All beneficiaries
  - b. \_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

3. \_\_\_\_ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

**Section D – Benefits**

*Benefits:*

1. \_\_\_\_ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. X The agency makes the following adjustments to benefits currently covered in the state plan:

Effective September 1, 2020, to maintain a stable workforce and provider pool, and to preserve the significantly impacted HCBS provider networks affected by the continued shortage of provider staff, the State will temporarily modify the service scope for selected 1915i services. The temporary modification will allow for service delivery flexibilities to respond to the extenuating circumstances created by the COVID-19 pandemic, to prevent spread of illness, and to best manage the health, safety, and well-being of participants. The modifications of service scope are:

- Delivery of protective supplies and equipment related to COVID-19
- Training in the use of equipment and/or supplies that are needed to access services remotely.
- Delivery and set-up of equipment and/or supplies needed to access services remotely

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

The temporary modification will apply to the following 1915i services:

- Day Services
- Non-Medical Transportation
- Prevocational Services
- Supported Employment Services

The modifications to these services have been established to assure access to needed home and community-based services in support of the individual's health and safety during the COVID-19 pandemic.

3. \_\_\_\_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
4. \_\_\_\_ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
- a. \_\_\_\_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. \_\_\_\_ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

*Telehealth:*

5.  X  The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Face-to-face requirement: Effective March 1, 2020, modify face-to-face requirement for State Plan services listed below to be provided via all forms of telehealth and telephone, regardless of originating or distant site. This affords providers the flexibility to safely and expeditiously render necessary care for people when they are not physically present with the individual. The following services may be provided via telehealth:

- Habilitation - Day Services
- Habilitation - Behavioral Intervention Services
- Occupational Therapy

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

- Physical Therapy
- Psychology Services
- Enhanced Habilitation - Prevocational Services
- Communication Aides
- Housing Access Services
- Enhanced Habilitation - Supported Employment Individual
- Speech, Hearing, and Language Services
- Habilitation - Community Living Arrangements

Remote delivery of services (telehealth) expands access to supports and services to a broader community not limited by the individuals' geographic location, increasing an individual's ability to integrate with others in activities of their choice. Remotely delivered services can be provided to multiple individuals at one time (without sharing private health information), which presents individuals with the opportunity to interact with others, while maintaining safety measures needed due to the PHE.

Telehealth delivery will ensure continuity of services and allow for individuals to maintain relationships with their service providers, which may have otherwise been paused or disrupted in absence of telehealth delivery. In-person services may still be conducted, if deemed necessary, as agreed upon by the consumer and provider.

Telehealth will be provided only if it meets the needs of the consumer, and individuals requiring physical assistance will need to work with their providers to arrange such services. Telehealth service will not replace personal care supports. If personal care is needed while telehealth is being provided, the individual and/or person supporting the individual will conduct personal care activities out of the line of sight of the telehealth provider, turn off video/audio communication during that time, or reschedule the telehealth visit. In instances where privacy cannot be secured by the individual, the telehealth provider will pause the telehealth service until confirming it was appropriate to resume.

The individual's person-centered planning team is responsible for determining the extent of training necessary for the individual to access their services remotely. Family members may also be eligible for training, as appropriate, to support the provision of services if determined to be beneficial for the participant.

Under the Medi-Cal Telehealth Policy, temporary policy changes were implemented during the PHE that allow for expanded access to telehealth through non-public technology platforms. This "good faith" exemption was granted by the federal Office for Civil Rights, which would otherwise not be allowed under federal Health Insurance Portability and Accountability Act (HIPAA) requirements. Nonetheless, the state will continue to follow HIPAA compliance when at all possible.

Additionally, providers must make reasonable efforts to limit the information disclosed to that which is "minimum necessary" to accomplish the purpose. Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements in connection with the provision of their video communication products.

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

State law identifies a bill of rights for people with developmental disabilities (Welfare and Institutions Code section 4502) including the right to dignity, privacy, and humane care. All regional center services and supports are subject to these provisions. When services are provided via telehealth, the provider is expected to confirm that the individual is in a setting appropriate for the type of service being provided.

*Drug Benefit:*

6. \_\_\_\_ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

7. \_\_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. \_\_\_\_ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

9. \_\_\_\_ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E – Payments**

*Optional benefits described in Section D:*

1. \_\_\_\_ Newly added benefits described in Section D are paid using the following methodology:

- a. \_\_\_\_ Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

b.  Other:

Describe methodology here.

*Increases to state plan payment methodologies:*

2.  The agency increases payment rates for the following services:

*Please list all that apply.*

a.  Payment increases are targeted based on the following criteria:

*Please describe criteria.*

b. Payments are increased through:

i.  A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

ii.  An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: \_\_\_\_\_

Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

Up to the Medicare payments for equivalent services.

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

\_\_\_\_\_ By the following factors:

*Please describe.*

*Payment for services delivered via telehealth:*

3. \_\_\_\_\_ For the duration of the emergency, the state authorizes payments for telehealth services that:

- a. \_\_\_\_\_ Are not otherwise paid under the Medicaid state plan;
- b. \_\_\_\_\_ Differ from payments for the same services when provided face to face;
- c. \_\_\_\_\_ Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- d. \_\_\_\_\_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i. \_\_\_\_\_ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii. \_\_\_\_\_ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

4.   X   Other payment changes:

When the temporary service scope modifications are in effect, the billing process will be as follows:

Payments to qualified providers for the above listed service modifications will only be for individuals enrolled in the 1915(i) HCBS State plan benefit and based on each provider's traditional rate (e.g. daily or hourly rate) for the respective service converted to a monthly rate. The conversion to the monthly rate is done by multiplying the daily or hourly rate by the average number of units of service per month provided to individuals during the 12-month period ending February 2020. The average monthly utilization is provider-specific and is based on each provider's unique provision of service for the specified timeframe. There will be no changes in billing process or rates for providers who continue to provide services under the

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

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regular scope of service. Providers will keep records of each individual's frequency of participation in the modified service and will submit billing for the monthly rate only for individuals who have elected to receive services under the temporarily modified scope of service. The state will periodically monitor the actual provision of services to ensure that individuals receive the appropriate type, quantity, and intensity of services required to meet their needs and to ensure that the rates remain economic and efficient based on the services that are actually provided.

Any provider delivering services through a bundle will be paid through that bundle's payment rate and cannot bill separately; Medicaid providers delivering separate services outside of the bundle may bill for those separate services in accordance with the state's Medicaid billing procedures. At least one (1) service must be rendered to the beneficiary during the month in order for the provider to bill for the monthly rate for the beneficiary under the modified billing process as described above.

#### **Section F – Post-Eligibility Treatment of Income**

1. \_\_\_ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a. \_\_\_ The individual's total income
  - b. \_\_\_ 300 percent of the SSI federal benefit rate
  - c. \_\_\_ Other reasonable amount: \_\_\_\_\_
2. \_\_\_ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

#### **Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

This SPA is in addition to all previously approved disaster relief SPAs and does not supersede anything approved in those SPAs.

State/Territory: California

Page: 102

Disaster Relief SPA #15

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

TN: 22-0037

Supersedes TN: None

Approval Date: 07/22/2022

Effective Date: 03/01/2020

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