

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

1. TRANSMITTAL NUMBER

1 9 - 0 0 16

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

January 1, 2019

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)(29), SSA 1902 (k)(1), 42 CFR 440.170

7. FEDERAL BUDGET IMPACT

a. FFY 2019 \$ 836,958

b. FFY 2020 \$ 1,115,943

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Adding comprehensive vision services to the LEA portion of the ABP.

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT

OTHER, AS SPECIFIED

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

16. RETURN TO

Department of Health Care Services

Attn: Director's Office

P.O. Box 997413, MS 0000

Sacramento, CA 95899-7413

13. TYPED NAME

Mari Cantwell

14. TITLE

State Medicaid Director

15. DATE SUBMITTED

March 29, 2019

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.



Alternative Benefit Plan

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 routine eye exam in 24 months

Duration Limit:

None

Scope Limit:

Orthoptics, pleoptics and glasses are not covered.

Other:

Glasses and contact lenses are covered for EPSDT and pregnant women.

Other 1937 Benefit Provided:

Local Education Agency Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medi-Cal eligible public school children up to age 22 or end of school year beneficiary turns 22.

Other:

Services provided by Individualized Education Plan, Individualized Family Service Plan, California Children Services, Short-Doyle, or prepaid health plan. Services include health and mental health evaluation and education, individualized education plan, individualized family service plan, physician services, physical therapy, occupational therapy, speech therapy, audiology services, comprehensive vision services, psychology and counseling, nursing services, school health aid services, medical transportation/mileage and targeted care management services.

Other 1937 Benefit Provided:

TCM: Children at Risk of Medical Compromise

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Children up to age 21.

Other:

1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes children who need assistance to access medical, social and education services when