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State/Territory Name: California

State Plan Amendment (SPA) #: 25-0009

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

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

Medicaid and CHIP Operations Group

April 7, 2026

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

Re: California State Plan Amendment (SPA) 25-0009

Dear Director Sadwith:

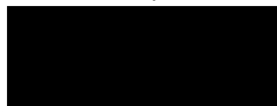
The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0009. This amendment proposes to add encounters between a patient and a psychological associate for Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal FQHCs as Prospective Payment System billable visits; removes the Change in Scope of Services Request requirement when adding Marriage and Family Therapist services for FQHCs and RHCs; and makes one technical correction related to Intermittent Clinic and Mobile Unit allowable hours.

We conducted our review of your submittal according to statutory requirements at Section 1902(bb) of the Social Security Act and implementing regulation 42 CFR 447. This letter is to inform you that California Medicaid SPA 25-0009 was approved on April 6, 2026, with an effective date of January 1, 2025.

Enclosed are copies of CMS Form 179 and approved SPA pages to be incorporated into the California State Plan.

If you have any questions, please contact Nikki Lemmon at Nicole.Lemmon@cms.hhs.gov.

Sincerely,



Digitally signed by Nicole M. Mcknight -S
Date: 2026.04.07 10:55:23 -04'00'

Nicole McKnight
Acting Director, Division of Program Operations

Enclosures

cc: Lindy Harrington, DHCS
Angeli Lee, DHCS
Shanna Haysbert, 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: 2 5 — 0 0 0 9

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: January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447; Section 1902(bb) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024-25 $ 0
b. FFY 2025-26 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Limitations on Attachment 3.1-A, pages 3b.1 and 3d.2
Limitations on Attachment 3.1-B, pages 3b.1 and 3d.2
Attachment 4.19-B, pages 6B.1, 6E, ~~and~~ 6W, 6C, 6R, 6R.1 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Limitations on Attachment 3.1-A, pages 3b.1 and 3d.2
Limitations on Attachment 3.1-B, pages 3b.1 and 3d.2
Attachment 4.19-B, pages 6B.1, 6E, ~~and~~ 6W, 6R, 6C

9. SUBJECT OF AMENDMENT
Adds encounters between a patient and a psychological associate for FQHCs, RHCs, and Tribal FQHCs as PPS billable visits, removes the Change in Scope of Services Request requirement when adding Marriage and Family Therapist services for FQHCs and RHCs, and makes one technical correction related to Intermittent Clinic and Mobile Unit allowable hours.

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

12. TYPED NAME
Tyler Sadwith

13. TITLE
State Medicaid Director and Chief Deputy Director

14. DATE SUBMITTED
March 27, 2025

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

FOR CMS USE ONLY

16. DATE RECEIVED: March 27, 2025

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL: Nicole McKnight

21. TITLE OF APPROVING OFFICIAL: Acting Director, Division of Program Operations

22. REMARKS

1/13/26: State authorizes P&I to add pages 4.19-B pages 6C and 6R-6R.1 to box 7

2/10/25: State authorizes a P&I to add page 6R and 6C to box 8

FORM CMS-179 (09/24)

Instructions on Back

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2b. Rural Health Clinic (RHC) services and other ambulatory services covered under the State Plan (continued)	15. Psychological Associate who is registered with the Board of Psychology and is supervised by a clinical psychologist licensed by the Board of Psychology. The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	a) A Psychological Associate's supervisor is identified by the Board of Psychology requirements. b) A clinical psychologist is a qualified licensed practitioner and must comply with the supervision requirements established by the Board of Psychology.

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

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2c. and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the State Plan (continued)	14. Associate Professional Clinical Counselor (APCC) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Clinical Psychologist, or a Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology.	a) An APCC supervisor is identified by the Board of Behavioral Science (BBS) requirements. b) The APCC supervisor is a qualified, licensed practitioner and must comply with supervision requirements established by the BBS.
	15. Psychological Associate who is registered with the Board of Psychology and is supervised by a clinical psychologist licensed by the Board of Psychology.	a) A Psychological Associate's supervisor is identified by the Board of Psychology requirements. b) A clinical psychologist is a qualified licensed practitioner and must comply with the supervision requirements established by the Board of Psychology.

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

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2b. Rural Health Clinic services and other ambulatory services covered under the State Plan (continued)	15. Psychological Associate who is registered with the Board of Psychology and is supervised by a clinical psychologist licensed by the Board of Psychology. The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, and speech therapy.	a) A Psychological Associate's supervisor is identified by the Board of Psychology requirements. b) A clinical psychologist is a qualified licensed practitioner and must comply with the supervision requirements established by the Board of Psychology.

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

STATE PLAN CHART

Type of Service	Program Coverage**	Prior Authorization or Other Requirements*
2c. and 2d. Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the State Plan (continued)	14. Associate Professional Clinical Counselor (APCC) who is registered with the California Board of Behavioral Sciences and is supervised by a Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Clinical Psychologist, or a Licensed Physician certified in Psychiatry by the American Board of Psychiatry and Neurology.	a) An APCC supervisor is identified by the Board of Behavioral Science (BBS) requirements. b) The APCC supervisor is a qualified, licensed practitioner and must comply with supervision requirements established by the BBS.
	15. Psychological Associate who is registered with the Board of Psychology and is supervised by a clinical psychologist licensed by the Board of Psychology.	a) A Psychological Associate's supervisor is identified by the Board of Psychology requirements. b) A clinical psychologist is a qualified licensed practitioner and must comply with the supervision requirements established by the Board of Psychology.

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

(b) Optional services that are furnished by an FQHC and RHC within the scope of subparagraph C.1(a), or any other provision of this State Plan, are covered only to the extent that they are identified in the State Plan segments titled, "Limitations on Attachment 3.1-A" and "Limitations on Attachment 3.1-B" on pages 3 through 3e, effective July 1, 2016.

(c) Medi-Cal services that are furnished by an FQHC or RHC, and that are out of the scope of subparagraph C.1(a), are paid under the associated benefit where the approved services are covered in State Plan segments titled, “Limitations on Attachment 3.1-A” and “Limitations on Attachment 3.1-B.” Such services are ineligible for PPS reimbursement and are reimbursed through the Fee-For-Service (FFS) delivery system in this State Plan. These services included, but are not limited, to the below:
    (i) Certified Wellness Coach.

2. Effective January 1, 2025, a "visit" for purposes of reimbursing FQHC or RHC services includes any of the following:

    a. A face-to-face encounter or an interaction using synchronous audio-only or asynchronous modality, between an FQHC or RHC patient and one of the following practitioners hereafter referred to as a “health professional,” to the extent the services are reimbursable as covered benefits under C.1(a). Associates must be under the supervision of a licensed mental health professional, in accordance with their scope of practice and applicable state laws:
        i. Doctor of Medicine or Osteopathy.
        ii. Doctor of Podiatry.
        iii. Doctor of Optometry.
        iv. Doctor of Dental Surgery Dentist.
        v. Chiropractor.
        vi. Acupuncturist.
        vii. Resident in a teaching health center graduate medical education program.
        viii. Clinical Psychologist.
        ix. Licensed Clinical Social Worker.
        x. Licensed Marriage and Family Therapist.
        xi. Licensed Professional Clinical Counselor.
        xi. Associate Clinical Social Worker.
        xii. Associate Marriage and Family Therapist.
        xiii. Associate Professional Clinical Counselor.
        xiv. Psychological associate.
        xv. Physician assistant.
        xvi. Nurse practitioner.
        xvii. Certified nurse midwife.
        xviii. Registered dental hygienist or registered dental hygienist in

alternative practice.

xix. Visiting nurse as defined in Title 42 of the Code of Federal Regulations, Section 405.2416.

b. Comprehensive perinatal services, when provided by a comprehensive perinatal service practitioner.

RHC, the prospective payment reimbursement rate for the first fiscal year was calculated by adding the visit rate for fiscal years 1999 and 2000, and then dividing the total by two.

(b) If the cost per visit for the period(s) used to establish the prospective payment reimbursement rate in subparagraph b.2(a) was calculated using a visit definition that does not conform to Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certify to its authenticity within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC to determine whether a rate adjustment was necessary. This subparagraph D.2(b) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

3. Services provided at intermittent service sites or mobile facilities that are affiliated with an FQHC or RHC are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when the facility is owned or operated by the same entity and licensed or enrolled as a Medi-Cal provider.

4. Effective October 1st of each year, for services furnished on and after that date, DHS will adjust the rates established under paragraph D.2 by the percentage increase in the MEI applicable to primary care services (as defined in Section I 842(i)(4) of the Act) as published in the Federal Register for that calendar year.

5. DHS will notify each FQHC and RHC of the effect of the annual MEI adjustment.

E. Alternative Payment Methodology Using the Reported Cost-Based Rate for the Fiscal Year Ending in Calendar Year 2000

An FQHC or RHC that elected the alternative payment methodology under this Section E receives reimbursement under the following provisions:

1. Each FQHC and RHC that elected to receive payment in an amount calculated using the alternative payment methodology described in this Section E, the rate was effective the first day of the fiscal year that began on or after January 1, 2001. For the period January I, 2001, until the payment methodology described in this Section E became effective for the

the particular FQHC's or RHC's 2003 fiscal year. For any FQHC or RHC that has a July 1, 2002, to June 30, 2003, fiscal year (as described in the example above), October 1, 2003, is the date of the MEI, which will be applied to the July 1, 2002, to September 30, 2003, established PPS rate. For any FQHC or RHC that has a January 1, 2003, to December 31, 2003, fiscal year, October 1, 2004, is the date the MEI will be applied to the January 1, 2003, established PPS rate.

7. A written request under Section K must be made to DHS and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DHS. Costs must not be reported twice for duplicate reimbursement. Costs arising from extraordinary circumstances and for which the FQHC or RHC has either been reimbursed or for which supplemental reimbursement is pending under Section G will not be reimbursable as a scope-of-service rate change under either Sections F or K.

8. Rate adjustments for scope-of-service changes under this Section K for an FQHC's or RHC's fiscal year ending in 2004, were deemed to have been filed in a timely manner so long as they were filed within 90 days following the end of the 150 day timeframe applicable to retroactive scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year or the date the scope-of-service forms are received, whichever is later.

9. Notwithstanding paragraphs (1) and (2) in this Section, if an FQHC’s or RHC’s PPS rate included the cost of Marriage and Family Therapist (MFT) services prior to January 1, 2018, the FQHC or RHC shall apply for an adjustment to its PPS rate by utilizing the change in scope of services request forms to determine the FQHC’s or RHC’s rate before billing encounters with MFTs as a separately reimbursable PPS visit. The FQHC or RHC must apply for an adjustment within 150 days following the FQHC’s or RHC’s fiscal year end. The rate adjustment request must include one full fiscal year (12 months) of MFT costs and visits. Rate changes are based on an FQHC’s or RHC’s application for a rate adjustment, and DHCS’s reconciliation of costs and visits shall be evaluated in accordance with Medicare’s reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

L. Administration of Managed Care Contracts

1. Where an FQHC or RHC furnishes services pursuant to a contract

with a managed care entity (MCE) (as defined in Section 1932(a)(l)(B) of the Act), DHS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

2. Supplemental payments made pursuant to paragraph L.1. will be governed by the provisions of subparagraph (a) through (d), below.

(a) FQHCs and RHCs that provide services under a contract with a MCE will receive, at least quarterly, state supplemental payments for such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCEs and the payments the FQHC or RHC would have received under the PPS and/or APM methodology described in this Attachment.

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