

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: **California**
Transmittal Number: **CA-25-0007**

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

CA 25-0007 ABP Updates for SPAs 24-0003, 24-0031, 24-0042, 24-0052, 25-0006, 25-0009, and 25-0014.

Description:

Alignment of the Alternate Benefit Plan (ABP) with the updates made by SPAs 24-0003, 24-0031, 24-0042, 24-0052, 25-0006, 25-0009, and 25-0014.

- ☐ The state attests that this SPA does not make a substantive change and therefore does not require the state to provide public notice in accordance with 42 CFR 440.386.
- ☒ Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

Date public notice was issued (mm/dd/yyyy)

- ☒ The state/territory assures that it has provided the public with advance notice of the amendment and reasonable opportunity to comment.
- ☒ The state/territory assures that it has included in the notice a description of the method for assuring compliance with 42CFR 440.345 related to full access to EPSDT services.
- ☒ The state/territory assures that it has included in the notice a description of the method for complying with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009.
- ☒ The state/territory assures that it has performed any required tribal consultation.

Upload Public Notice Documents

Please provide a short description of this public notice:

This notice is to provide information of public interest about a proposed SPA #25-0007 by DHCS. SPA #25-0007 seeks federal approval to align the Alternate Benefit Plan (ABP) with the updates

Uploaded Document Name:

Date Uploaded:

SPA-25-0007-Public-Notice.pdf

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- ☐ **The population group for this Alternative Benefit Plan includes only the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*
- ☒ **The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*
- ☐ **The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

- ☐ Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*

0

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: **California**
Transmittal Number: **CA-25-0007**

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2c	Enrollment Assurances - Mandatory Participants	0
ABP3	ABP3-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only if ABP has an effective date prior to 1/1/2020 or if only changing the section 1937 Coverage Option of an ABP implemented prior to 1/1/2020) or ABP3.1-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only for ABP's effective on or after 1/1/2020)	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	0
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form: SPA 25-0007 ABP1 - submitted March 28, 2025
Uploaded Form Name: 20250328_CA-25-0007_ABP1.pdf
Date Uploaded:

Support Documents

Document

Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a Forms List

Form

Please provide a short description of this ABP2a form:

SPA 25-0007 ABP2a - submitted March 28, 2025

Uploaded Form Name:

Date Uploaded:

20250328_CA-25-0007_ABP2a.pdf

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form

Please provide a short description of this ABP2b form:

SPA 25-0007 ABP2b - submitted March 28, 2025

Uploaded Form Name:

Date Uploaded:

20250328_CA-25-0007_ABP2b.pdf

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List


Form

Support Documents

Document

Form ABP3: ABP3-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only if ABP has an effective date prior to 1/1/2020 or if only changing the section 1937 Coverage Option of an ABP implemented prior to 1/1/2020). Or ABP3.1-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only for ABP's effective on or after 1/1/2020).

ABP3 Forms List


Form	
Please provide a short description of this ABP3 form:	
SPA 25-0007 ABP3 - submitted March 28, 2025	
	
Uploaded Form Name:	Date Uploaded:
20250328_CA-25-0007_ABP3.pdf	

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List


Form	
Please provide a short description of this ABP4 form:	
SPA 25-0007 ABP4 - submitted March 28, 2025	
	
Uploaded Form Name:	Date Uploaded:
20250328_CA-25-0007_ABP4.pdf	

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form	
Please provide a short description of this ABP5 form:	
SPA 25-0007 ABP5 - submitted March 28, 2025	
	
Uploaded Form Name:	Date Uploaded:
20250328_CA-25-0007_ABP 5.pdf	

Support Documents

Document

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form

Please provide a short description of this ABP8 form:

SPA 25-0007 ABP8 - submitted March 28, 2025

Uploaded Form Name:

Date Uploaded:

20250328_CA-25-0007_ABP8.pdf

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form

Please provide a short description of this ABP9 form:

SPA 25-0007 ABP9 - submitted March 28, 2025

Uploaded Form Name:

Date Uploaded:

20250328_CA-25-0007_ABP9.pdf

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form
Please provide a short description of this ABP10 form: SPA 25-0007 ABP10 - submitted March 28, 2025
Uploaded Form Name: 20250328_CA-25-0007_ABP10.pdf
Date Uploaded:

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form
Please provide a short description of this ABP11 form: SPA 25-0007 ABP11 - submitted March 28, 2025
Uploaded Form Name: 20250328_CA-25-0007_ABP11.pdf
Date Uploaded:

Support Documents

Document

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: California
Transmittal Number: CA-25-0007

- ☒ One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.
- ☒ This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.
- ☒ The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.
- Complete the following information regarding any tribal consultation conducted with respect to this submission: Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:*

- ☐ Indian Tribes
- ☐ Indian Health Programs
- ☐ Urban Indian Organization

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Document	
Please provide a short description of this support document:	
SPA 25-0007 Tribal Notice, released on February 21, 2025	
Uploaded Document Name: SPA 25-0007 Tribal Notice.pdf	Date Uploaded:

Indicate the key issues raised in Indian consultative activities:

- ☐ Access

Summarize Comments

Summarize Response

- ☐ Quality

Summarize Comments

Summarize Response

- ☐ Cost

Summarize Comments

Summarize Response

- ☐ Payment methodology

Summarize Comments

Summarize Response

- ☐ Eligibility

Summarize Comments

Summarize Response

- ☐ Benefits

Summarize Comments**Summarize Response**☐ **Service delivery****Summarize Comments****Summarize Response**☐ **Other Issue**

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name:

California

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

CA-25-0007

Proposed Effective Date

01/01/2025

(mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR Part 438, 42 CFR 438.6

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2025	\$ 319000.00
Second Year	2026	\$ 425239.00

Subject of Amendment

SPA 25-0007 aligns the Alternative Benefit Plan with SPAs 24-0003, 24-0031, 24-0042, 24-0052, 25-0006, 25-0009, and 25-0014.

Governor's Office Review

- ☐ Governor's office reported no comment
- ☐ Comments of Governor's office received

Describe:

- ☐ No reply received within 45 days of submittal
- ☒ Other, as specified

Describe:

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

Signature of State Agency Official

Submitted By:	Angeli Lee
Last Revision Date:	Mar 28, 2025
Submit Date:	Mar 28, 2025