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State/Territory Name: California

State Plan Amendment (SPA) #: 25-0014

This file contains the following documents in the order listed:

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

June 24, 2025

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) 25-0014

Dear Director Sadwith:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0014. This amendment adds Certified Wellness Coach Services as a new benefit.

We conducted our review of your submittal according to statutory requirements at 42 CFR 440.130(c), Section 1905(a)(13) and 1902(bb) of the Social Security Act. This letter is to inform you that California Medicaid SPA 25-0014 was approved on June 24, 2025, 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,

Shantrina Roberts, Acting Director
Division of Program Operations

Enclosures

cc: Tyler Sadwith, DHCS
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: 25-0014

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 XIX of the Social Security Act, Section 1905(a)(13); 1902(bb) and;
42 CFR 440.130(c)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 563,000
b. FFY 2026 $ 750,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Limitations on Attachments 3.1-B, pages 18l ~~and 18m~~ (new)
Limitations on Attachments 3.1-A, pages 18l ~~and 18m~~ (new)
~~Attachment 4.19-B, pages 6AA17 and 6AA18 (new)~~
Attachment 4.19-B pages 6B.1, 6L-6L.1, 6O-6O.1, ~~and~~ 6S, ~~6S.1~~ 6R

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~None~~
4.19-B pages 6.B.1, 6L, 6O, 6R, 6S

9. SUBJECT OF AMENDMENT
Add Certified Wellness Coach Services as a New Benefit

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
June 24, 2025

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
Shantrina Roberts

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

22. REMARKS
5/23/25: State authorizes P&I change to:
- Box 5 to reflect: 1905(a)(13) and 1902(bb) and 42 CFR 440.130(c)
- Box 7 to remove 6AA17 and 6AA18; and add 6B.1, 6L-6L.1, 6O-6O.1, and 6S-6S.1

6/16/25: State authorizes P&I change to:
- Box 7: to remove 6.S.1 and add 6R & 18m;
- Box 8: to add 6.B.1, 6L, 6O, 6R, 6S

Instructions on Back

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c. Certified Wellness Coach Services	Certified Wellness Coach services are preventive services, as defined in 42 CFR 440.130(c), to support behavioral health needs and promote physical and mental health. Certified Wellness Coaches operate as part of a care team to provide the following services: • Wellness promotion and education. • Screening not requiring a licensed provider. • Care coordination including navigation services. • Individual and group behavioral health coaching, including wellness education, coping skills, goal setting and planning, teaching life skills, stress management, and problem solving. • Crisis referral, including identifying potential risk, providing emotional support, and engaging in warm handoffs with licensed, credentialed, or associate behavioral health providers. Certified Wellness Coach services do not include the following: • Assessing, diagnosing, or providing clinical intervention or treatment. • Providing clinical referrals.	Pursuant to 42 CFR Section 440.130(c), Certified Wellness Coach services are recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Certified Wellness Coaches must be supervised by a licensed practitioner or an individual holding a valid Pupil Personnel Services (PPS) credential issued by the Commission on Teacher Credentialing. . Certified Wellness Coaches must demonstrate minimum qualifications by possession of a Certified Wellness Coach certificate issued by the state or a state-approved vendor.

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

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* 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 April 1, 2024, 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 a physician, a resident in a Teaching Health Center Graduate Medical Education Program under the supervision of a teaching physician, an Associate Clinical Social Worker, Associate Marriage and Family Therapist, or Associate Professional Clinical Counselor under the supervision of a billable behavioral practitioner accredited by the Behavioral Sciences Board, Licensed Professional Clinical Counselor, physician assistant, nurse practitioner, acupuncturist, certified nurse

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal year of the facility's operation at the new site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph 0.4.

4. Rate setting for a new facility under Section J shall exclude costs associated with out of scope services that are ineligible for PPS reimbursement, under Section C.1.

5. If a new facility does not respond within 30 days of DHCS' request for three comparable FQHCs or RHCs as described in subparagraph J.3(a) or the projected allowable costs as described in subparagraph J.3(b), DHCS will suspend processing of the new facility's request for reimbursement as an FQHC or RHC, until the required information has been provided.

6. The effective date for the rate of a new facility under Section J is retroactive to the later of the date that the licensed FQHC or RHC was federally qualified as an FQHC or RHC, or the date a new FQHC or RHC at a new location was added to an existing FQHC or RHC as a licensed or enrolled Medi-Cal provider.

(a) An FQHC or RHC may continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number. Until its FQHC or RHC provider number is received, a facility must not bill the Medi-Cal program using the FQHC or RHC provider number of another facility. The preceding sentence will not apply to intermittent service sites that are affiliated with an FQHC or RHC and that operate less than 20 hours per week or in mobile facilities.

(b) DHCS will reconcile the difference between the fee-for-service payments and the FQHC's or RHC's PPS rate following· notification to the provider that its FQHC or RHC

number has been activated.

7. In order to establish comparable FQHCs or RHCs providing similar services, DHCS will require all FQHCs or RHCs to submit to DHCS either of the following:

at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C. 1.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C. 1.

3. An FQHC or RHC may submit a request for scope-of-service changes once per fiscal year, within 150 days of the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred. Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

4. An FQHC or RHC must submit a scope-of-service rate change request within 150 days of the beginning of any FQHC's or RHC's fiscal year occurring after the effective date of this Section K if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope-of-services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If any FQHC or RHC discontinues providing onsite pharmacy or dental services, it must submit a scope-of-service rate change request within 150 days of the beginning of the fiscal year following the year in which the change occurred. As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

5. Scope-of-service rate changes under this section shall exclude costs associated with out of scope services that are ineligible for PPS reimbursement, under Section C.1.

6. Notwithstanding paragraph K.4, if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change will be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph must be submitted within 150 days after the adoption and issuance of the written instructions by DHCS.

7. The reimbursement rate for scope-of-service changes implemented within the FQHC's or RHC's fiscal year ending in calendar year 2004 and

8. subsequent fiscal years will be calculated as follows:

(a) If DCHS determines that documentation submitted by the FQHC or RHC accurately reflects the cost per-visit rate calculation for that particular year, DHCS will subtract the current PPS per-visit rate from the newly calculated per-visit rate for that particular year. The "current PPS per-visit rate" means the PPS per-visit rate in effect on the last day of the reporting period during which the scope-of-service change occurred.

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.

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.

(b) At the end of each FQHC's or RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the PPS and/or APM methodology described in this Attachment.

(c) If the amount calculated using the PPS and/or APM methodology described in this Attachment exceeds the total amount of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the PPS and/or APM amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amount calculated using the PPS and/or APM methodology described in this Attachment is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount calculated using the PPS and/or APM methodology described in this Attachment and the total amount of supplemental and MCE payments received by the FQHC or RHC.

3. Payments made to any FQHC or RHC for FQHC or RHC services under managed care contracts, as described in paragraphs 1 and 2 of this Section L, will exclude any financial incentive payments to the FQHC or RHC that are required by federal law to excluded from the calculation described in paragraph L.2.

4. Payments made to any FQHC or RHC under managed care contracts, as described in paragraphs 1 and 2 of this Section L, for out of scope services that are ineligible for PPS reimbursement, under Section C.1, shall be excluded from the calculation described in paragraph L.2.

M. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Prevention (CHDP) Program Coverage

1. Where a recipient has coverage under the Medicare or the CHDP program, DHCS will supplement the payment from those programs not to exceed the prospective payment reimbursement rates established under this Amendment.

2. Where an FQHC or RHC services are partially reimbursed by a third party such as CHDP, DHCS will reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate. Such reimbursement may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.