DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

SEP 12 2011

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue,
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) Number 11-012, which implements California CWI code Section 14131.05 which requires DHCS to cap the maximum amount of Medical coverage for optional hearing aid benefits at $1,510 per beneficiary for each fiscal year. The SPA is effective November 1, 2011. Attached are copies of the following new pages to be incorporated into your State Plan:

Attachment 3.1-A, Page 5
Limitations on Attachment 3.1-A, Page 14
Limitations on Attachment 3.1-A, Page 18 & 18a
Limitations on Attachment 3.1-B, Page 14
Limitations on Attachment 3.1-B, Page 18 & 18a
Attachment 3.1-B, Pages 4&5

If you have any questions, please contact Rodd Mas at (415) 744-2978 or via email at rodd.mas@cms.hhs.gov.

Sincerely,

Gloria Nagle

Gloria Nagle, Ph.D., M.P.A.
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Vickie Orlich, California Department of Health Care Services
Janice Spitzer, California Department of Health Care Services
Kathyryn Waje, California Department of Health Care Services
Christopher Thompson, Centers for Medicare and Medicaid Services
Kara Ker, Centers for Medicare and Medicaid Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-012**

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 1, 2011

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:
42 U.S.C. 1396a, 42 CFR Part 440

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2011-12~~ 2012 $506,000 Reduction
b. FFY ~~2012-13~~ 2013 $695,000 Reduction

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1A, Page 5
Limitations on Attachment 3.1-A, Page 14
Limitations on Attachment 3.1-A, Page ~~14a~~ 18 &18a
Limitations on Attachment 3.1-B, Page 14
Limitations on Attachment 3.1-B, Page ~~14a~~ 18 &18a
Attachment 3.1-B, Pages 4&5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Page 5
Limitations on Attachment 3.1-A, Page 14, ~~XXXXXXXX~~
Limitations on Attachment 3.1-B, Page 14, ~~XXXXXXXX~~
Attachment 3.1-B, Pages 4&5
Limitations on Attachment 3.1-A, Page 18
~~Limitations on Attachment 3.1-B, Page 18~~

10. SUBJECT OF AMENDMENT:

Implementation of a $1,510 spending cap on optional hearing aid benefits per beneficiary, per fiscal year.

11. 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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: JUN 14 2011

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 14, 2011

18. DATE APPROVED: SEP 12 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
November 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Gloria Nagle

22. TITLE: Associate Regional Administrator

23. REMARKS:
Pen and Ink Changes to Boxes 7, 8 and 9 approved via email on August 29, 2011.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, prosthetic devices, and hearing aids; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Prosthetic devices and hearing aids.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

d. Eye glasses.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

*Description provided on attachment

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
7c.2	Durable medical equipment	Covered when prescribed by a licensed practitioner. DME commonly used in providing SNF and ICF level of care is not separately billable. Common household items are not covered.	Prior authorization is required when the purchase exceeds $100. Prior authorization is required when price, repairs, maintenance, or cumulative rental of listed items exceeds $25, except that the provision of more than two "H" oxygen tanks in any one month requires prior authorization. Purchase or rental of "By Report" (unlisted) items are subject to prior authorization regardless of purchase price. Authorization shall be granted only for the lowest cost item that meets medical needs of the patient.
7c.3	Hearing aids	Refer to Type of Service "12c Prosthetic and orthotic appliances, and hearing aids."	Refer to Type of Service "12c Prosthetic and orthotic appliances, and hearing aids."
7c.4	Enteral Formulae	Covered only when supplied by a pharmacy provider upon the prescription of a licensed practitioner within the scope of his or her practice. Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable. Common household items (food) are not covered.	Prior authorization is required for all products. Authorization is given when the enteral formulae is used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. Dietary supplements or products that cannot be used as a complete source of nutrition are considered non-benefits, except that the program may deem such a product a benefit when it determines that the use of the product is neither investigational nor experimental when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b Dentures	See 10.	See 10.
12c Prosthetic and orthotic appliances, and hearing aids.	Prosthetic and orthotic appliances are covered when prescribed by a physician or podiatrist. Stock shoes (conventional or orthopedic) are covered when at least one of the shoes is to be attached to a prosthesis or brace. Orthopedic modifications to stock shoes are also covered.	Prior authorization is required when the purchase price is more than $100. Prior authorization is required for rental or repair when the total cost is more than $50.
	Prosthetic eyes are covered when prescribed by a physician or other licensed practitioner performing within his or her scope of practice.	Prior authorization is required for prosthetic eyes and most prosthetic eye services.
	Hearing aids are covered only when supplied by a hearing aid dispenser upon the prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available. Loaner aids, during repair periods covered under guarantee, are not covered. Replacement batteries are not covered. Replacement of hearing aids that are lost, stolen, or irreparably damaged due to circumstances beyond the beneficiary's control is not included in the $1,510 maximum benefit cap. Hearing aid benefits are subject to a $1,510 maximum cap per beneficiary per fiscal year. Hearing aid benefits include hearing aids and hearing aid supplies and accessories. The following are exempted: • Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy. • Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program. • Beneficiaries who are receiving long-term care in a licensed skilled nursing facility or intermediate care facility (NF-A and NF-B).	Prior authorization is required for the purchase or trial period rental of hearing aids and for hearing aid repairs which exceed a cost of $25. Cords, receivers, ear molds, and hearing aid garments are covered without prior authorization. Authorization for hearing aids may be granted only when tests reveal an average loss of 35 dB or greater, or if the difference between the level of 1,000 Hertz and 2,000 Hertz is 20 dB or more. The hearing loss need only be 30 dB, and speech communication is effectively improved or the need for personal safety is met.

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

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12c Prosthetic and orthotic appliances, and hearing aids (continued).	• Beneficiaries who are receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including ICF/DD Habilitative and ICF/DD Nursing. • Beneficiaries in the Program for All-Inclusive Care for the Elderly (PACE). • Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation.	
12d. Eyeglasses and other eye appliances	Covered as medically necessary on the written prescription of a physician or an optometrist under this state plan only for the following beneficiaries: 1. Pregnant women if eyeglasses or other eye appliances are part of their pregnancy-related services or for services to treat a condition that might complicate the pregnancy. 2. Individual who is an eligible beneficiary under the Early and Periodic Screening Diagnosis and Treatment Program. 3. Individual who is receiving long term care in a licensed skilled or intermediate care facility (NF-A and NF-B). Services would be provided in an FQHC or RHC if an NF-A or NF-B resident is a patient of the clinic. 4. Individual who is receiving long term care in a licensed intermediate care facility for the developmentally disabled (ICF-DD) including ICF-DD Habilitative and ICF-DD Nursing.	Prior authorization is required for low vision devices when the billed amounts are over $100 and for contact lenses when medically indicated for conditions such as aphakia, keratoconus, anisometropia, or when facial pathology or deformity preclude the use of eyeglasses. Prior authorization is required for ophthalmic lenses and frames that cannot be supplied by the fabricating optical laboratory.
13a Diagnostic services	Covered under this state plan only for EPSDT program	
13b Screening services	Covered under this state plan only for EPSDT program	
13c Preventive services	Covered under this state plan only for EPSDT program and for pregnant/postpartum Medi-Cal recipient	

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

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO MEDICALLY NEEDY GROUP(S) _____

8. Private duty nursing services.

[ ] Provided: [ ] No limitations [ ] With limitations*

9. Clinic services.

[X] Provided: [ ] No limitations [X] With limitations*

10. Dental Services.

[X] Provided: [ ] No limitations [X] With limitations*

11. Physical therapy and related services.

a. Physical therapy.

[X] Provided: [ ] No limitations [X] With limitations*

b. Occupational therapy.

[X] Provided: [ ] No limitations [X] With limitations*

c. Services for individuals with speech, hearing and language disorders provided by or under supervision of a speech pathologists or audiologist.

[X] Provided: [ ] No limitations [X] With limitations*

12. Prescribed drugs, dentures, prosthetic devices, and hearing aids; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO MEDICALLY NEEDY GROUP(S) _____

c. Prosthetic devices and hearing aids.

[X] Provided: [ ] No limitations [X] With limitations*

d. Eye glasses.

[X] Provided: [ ] No limitations [X] With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[ ] Provided: [ ] No limitations [ ] With limitations*

b. Screening services

[ ] Provided: [ ] No limitations [ ] With limitations*

c. Preventive services.

[ ] Provided: [ ] No limitations [ ] With limitations*

d. Rehabilitative services; including rehabilitative mental health services and rehabilitative alcohol and drug treatment services for individuals diagnosed by physicians as having a substance-related disorder. (See Supplements 1, 2, and 3 to Attachment 3.1-B):

[X] Provided: [ ] No limitations [ ] With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

[X] Provided: [ ] No limitations [X] With limitations*

b. Skilled nursing facility services.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment

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7c.4	Enteral Formulae	Covered only when supplied by a pharmacy provider upon the prescription of a licensed practitioner within the scope of his or her practice. Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable. Common household items (food) are not covered.	Prior authorization is required for all products. Authorization is given when the enteral formulae is used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. Dietary supplements or products that cannot be used as a complete source of nutrition are considered non-benefits, except that the program may deem such a product a benefit when it determines that the use of the product is neither investigational nor experimental when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions.

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b Dentures	See 10.	See 10.
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TYPE OF SERVICE	PROGRAM COVERAGE	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12c Prosthetic, orthotic appliances, and hearing aids (continued)	• Beneficiaries who are receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including ICF/DD Habilitative and ICF/DD Nursing. • Beneficiaries in the Program for All-Inclusive Care for the Elderly (PACE). • Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation.	
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**Coverage is limited to medically necessary services

ENCLOSURE **FOR STAKEHOLDERS ONLY

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

11-012*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	Insert Page(s)
Attachment 3.1-B, page 4 (TN 88-8)	Attachment 3.1-B, page 4
Attachment 3.1-B, page 5 (TN 97-005)	Attachment 3.1-B, page 5
Limitations on Attachment 3.1-A, pages 18, 18a (TN 09-001)	Limitations on Attachment 3.1-A, pages 18, 18a
Limitations on Attachment 3.1-B, pages 14 (TN 03-12)	Limitations on Attachment 3.1-B, pages 14
Limitations on Attachment 3.1-B, pages 18, 18a (TN 09-001)	Limitations on Attachment 3.1-A, pages 18, 18a

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Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

11-012*

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