DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

JAN 23 2013

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

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 11-017. SPA 11-017 was submitted to my office on September 29, 2011 to add services that an optometrist is legally authorized to perform to the physician services section of the State Plan; the SPA also removes optometrist services from the other licensed practitioner services section of the State Plan. This SPA makes the necessary changes such that optometrists are eligible for the Electronic Health Record (EHR) incentive program.

The effective date of this SPA is October 1, 2011. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 3.1-A, page 3
- Limitations on Attachment 3.1-A, pages 10a.2 and 11
- Attachment 3.1-B, page 3
- Limitations on Attachment 3.1-B, pages 10a.2 and 11
- Section 3.1(f)(1), page 27

If you have any questions, please contact Kristin Dillon by phone at (415) 744-3579 or by email at Kristin.Dillon@cms.hhs.gov.

Sincerely,

Gloria Nagle

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

Enclosure

cc: Kathyryn Waje, California Department of Health Care Services
Pilar Williams, California Department of Health Care 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: **11-017**

2. STATE: **CA**

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
OCTOBER 01, 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:
SOCIAL SECURITY ACT 1905 (e)

7. FEDERAL BUDGET IMPACT:
a. FFY **$ N/A, NONE**
b. FFY **$ N/A, NONE**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 3.1 (f)(1), page 27; Attachment 3.1-A, page 3
~~Attachment 3.1A, item 6(b), page 3; 3.1B, item 6(b), page 3~~;
~~Limitations on Attachment 3.1A, item 5(a), page 10a, 3.1B, item 5(a), page 10a~~; Limitations on Attachment 3.1-A, pages 10a.2 & 11
~~Limitations on Attachment 3.1A, item 6(b), page 11, 3.1B, item 6(b) page 11~~ Attachment 3.1-B, page 3
Limitations on Attachment 3.1-B, pages 10a.2 & 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Replaces~~ Section 3.1(f)(1), page 27;
~~Replaces~~ Attachment 3.1A ~~and 3.1B, item 6(b)~~, page 3;
~~Replaces Limitations on Attachment 3.1A and 3.1B, item 5(a), page 10a~~; Attachment 3.1-B, page 3
~~Replaces~~ Limitations on Attachment 3.1A ~~and 3.1B, item 6(b)~~, page 11; Limitations on Attachment 3.1-B, page 11

10. SUBJECT OF AMENDMENT:
OPTOMETRIST AS ELIGIBLE PROVIDER

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: 9/28/11

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: 9/29/11

18. DATE APPROVED: JAN 23 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Gloria Nagle

22. TITLE: Associate Regional Administrator

23. REMARKS:
Pen and ink changes to boxes 8 & 9 confirmed via email on 1/10/13.

FORM HCFA-179 (07-92)

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a Physician's Services (continued)	Shall include services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist. Routine eye examinations with refraction are limited to one service in a 24 month period.	

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

State/ Territory: CALIFORNIA

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

b. Optometrists' services.

☐ Provided ☐ No limitations ☐ With Limitations*

☒ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With Limitations*

☐ Not provided.

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of limitations, if any.

☐ Not provided.

7. Home health services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: ☐ No limitations ☒ With Limitations*

b. Home health aide services provided by a home health agency.

Provided: ☐ No limitations ☒ With Limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: ☐ No limitations ☒ With Limitations*

*Description provided on attachment.

State/ Territory: CALIFORNIA

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

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

☒ Provided: ☐ No limitations ☒ With Limitations*

b. Optometrists' services.

☐ Provided ☐ No limitations ☐ With Limitations*

☒ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With Limitations*

d. Other practitioners' services.

☒ Provided: ☐ No limitations ☒ With Limitations*

7. Home health services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With Limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With Limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With Limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With Limitations*

*Description provided on attachment.

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a Physician's Services (continued)	Shall include services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist. Routine eye examinations with refraction are limited to one service in a 24 month period.	

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

STATE PLAN CHART

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6c Chiropractic services	Chiropractic services are covered under this state plan when provided by chiropractic practitioner licensed by the state. Chiropractic services are limited to manual manipulation of the spine. This is a covered optional benefit under this plan only for the following beneficiaries 1. Pregnant women, if chiropractic service is 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 (Continued on page 11A)	Prior authorization is not required; however, services are limited to a total of two services or any combination of two services per month from among the following: chiropractic, acupuncture, psychology, occupational therapy, speech therapy, and audiology. These limits do not apply to #1 and #2 in Program Coverage section. TAR is required if the requested services described above exceed more than two per month

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

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6c Chiropractic services	Chiropractic services are covered under this state plan when provided by chiropractic practitioner licensed by the state. Chiropractic services are limited to manual manipulation of the spine. This is a covered optional benefit under this plan only for the following beneficiaries 1. Pregnant women, if chiropractic service is 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.	Prior authorization is not required; however, services are limited to a total of two services or any combination of two services per month from among the following: chiropractic, acupuncture, psychology, occupational therapy, speech therapy, and audiology. These limits do not apply to #1 and #2 in Program Coverage section. TAR is required if the requested services described above exceed more than two per month

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

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometry services (other than those provided under §§435.531 and 436.531) are not now, but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

☒ Yes.

☐ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

☐ Not applicable. The conditions in the first sentence do not apply.

1903 (i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedure are provided.

☐ No.

☒ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners, who may provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

ENCLOSURE **FOR STAKEHOLDERS ONLY

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

11-017*

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)
None	Limitations on Attachment 3.1-A, page 10a.2 (add)
Limitations on Attachment 3.1-A, page 11 (TN 09-001)	Limitations on Attachment 3.1-A, page 11
Attachment 3.1-A, page 3 (TN 92-19)	Attachment 3.1, page 3
Attachment 3.1-B, page 3 (TN 88-8)	Attachment 3.1-B, page 3
None	Limitations on Attachment 3.1-B, page 10a.2 (add)
Limitations on Attachment 3.1-B, page 11 (TN 09-001)	Limitations on Attachment 3.1-B, page 11
Section 3.1, page 27 (TN 88-02)	Section 3.1, page 27