



TOBY DOUGLAS  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

June 28, 2013

Gloria Nagle, Ph.D., M.P.A.  
Associate Regional Administrator  
Division of Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services, Region IX  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6707

RESPONSE TO REQUEST FOR ADDITIONAL INFORMATION FOR STATE PLAN  
AMENDMENT 11-030

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting this response to the Request for Additional Information (RAI) for State Plan Amendment (SPA) 11-030. DHCS originally submitted SPA 11-030 in response to a companion letter received with the September 12, 2011, approval of SPA 11-012. In June 2012, DHCS received permission from the Centers for Medicare & Medicaid Services (CMS) to take SPA 11-030 "off the clock" until the *Federal Register*, Vol. 76, No. 133/Tuesday, July 12, 2011/Proposed Rules for home health services were finalized. CMS has since requested DHCS submit the RAI responses and revised state plan pages, because CMS anticipates the final federal regulations will reflect the same or similar policies for home health services as in the proposed regulations.

The RAI response answers questions regarding reimbursement for durable medical equipment (DME), hearing aids, and enteral nutrition, as well as general questions concerning page submissions. The pages submitted with the RAI bring the coverage description for item 7c.2 for DME and item 7c.4 for enteral nutrition into compliance with physician prescriptions, as required by Section 440.70 of Title 42 of the Code of Federal Regulations. SPA 11-030 also adds a reimbursement methodology for hearing aids and enteral nutrition to the state plan.

Ms. Gloria Nagle  
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Date

The enclosed SPA revises or adds language to the provisions set forth in the following pages:

- Attachment 4.19-B, pages 3i, 3i.1, and 3j
- Limitations on Attachment 3.1-A, page 14
- Limitations on Attachment 3.1-B, page 14

If you have any questions regarding the information provided, please contact, Laurie Weaver, Chief, Benefits Division, at (916) 552-9400 or by email at [laurie.weaver@dhcs.ca.gov](mailto:laurie.weaver@dhcs.ca.gov).

Sincerely,

**Original Document Signed By:**

Toby Douglas  
Director

Enclosures

cc: Donald A. Novo  
Division of Medicaid and Children's Health Operations  
San Francisco Regional Office  
Centers for Medicare and Medicaid Services  
90 Seventh Street, Suite 5-300(5W)  
San Francisco, CA 94103

**CMS Request for Additional Information SPA 11-030**  
**Sent February 29, 2012**  
**State's response dated May 29, 2013**

General Questions

1. Please redact from your submission and confirm pen and ink change to remove from the HCFA 179 the following pages:
  - a. 3.1-A, page 5,
  - b. Limitations on Attachments 3.1-A pages 18 and 18.a,
  - c. 3.1-B pages 4 and 5, and
  - d. Limitations on Attachments 3.1-B pages 18 and 18.a.

**State's response:** The State is removing from our submission the above listed pages and confirms the pen and ink changes to remove the listed pages from the HCFA 179. In addition, the State requests a pen and ink change to remove Attachment 4.19-B, pages 3a, 3d, 3d.1 and 3g from the HCFA 179. We are replacing these pages with Attachment 4.19-B, pages 3i, 3i.1, and 3j.

2. According to the correspondence in the file, the State is amending the prosthetics' section of the State Plan at item 12c in order to clarify that DME is also available to beneficiaries who are not receiving home health services and to be clear that the State provides these services outside of home health services. For the reasons that follow, an amendment to add that clarification to the prosthetics' section at item 12c is not appropriate.
  - a. Under regulations at 42 CFR 440.70, medical supplies, equipment, and appliances is a mandatory portion of the home health services benefit. Medical supplies, equipment and appliances are not limited to only people who are enrolled in a home health agency but also extend to beneficiaries who are not receiving home health services.
  - b. People who need medical supplies, equipment and appliances must have the need reviewed by a physician annually.

**State's response:** The State acknowledges it does not need to amend item 12c and is withdrawing pages 18 and 18a.

Reimbursement Questions:

1. Please confirm whether payment methodologies described in the proposed 4.19-B page 3d, 3d.1 and 3g reflect current payment methods for hearing aids, hearing aid supplies and accessories and enteral formulae. Please note that if the proposed payment methodologies described in 4.19-B results in any significant change in current payment methods and standards, public notice will be required according to 42 CFR 447.205.

**State's response:** The State confirms that the payment methodologies in the proposed Attachment 4.19-B, pages 3i, 3i.1, and 3j for these items reflect current payment methods.

2. Attachment 4.19-B, page 3d, item 6 (a), (b). Please explain the process of rate established by contracting program for hearing aids and hearing aid supplies and accessories. Also, please explain the difference between item 6(a) "The rate established by the contracting program" and 6(b) "The rate established by the department's contracting program."

**State's response:** The State does not have a contracting program for hearing aids at this time. In 2008, the State released a Request for Proposal for contracting of hearing aids, but did not receive any bids. However, the State is retaining the contracting program language in the State Plan for possible future implementation. Both items 6(a) and (b) should state, "The rate established by the Department's contracting program," as referenced in Attachment 4.19-B, page 3i.

3. Attachment 4.19-B, page 3d, item 6 (a), (b) and item 7. Please explain how the department determines the markup for hearing aids, hearing aids supplies and accessories, and enteral formulae.

**State's response:** The State developed a reimbursement methodology for hearing aids at the beginning of coverage in 1974. Hearing aid maximum allowances are for new instruments plus a markup, which includes up to six post-sale visits for training, adjustments and fitting, an initial standard package of batteries, a cord, receiver, and such other components normally required for the use of the new instrument. The State determines a markup that generally reflects the reasonable cost of the related services.

4. Attachment 4.19-B, page 3d, item 7. Please explain how the department determines the estimated acquisition cost for enteral formulae.

**State's response:** The State enters into contracts with manufacturers of enteral nutrition products for a maximum acquisition cost (MAC). The estimated acquisition cost (EAC) is based on the contracted MAC. On non-contracted products that are covered, the EAC is the average wholesale price minus 10 percent.

5. Attachment 4.19-B, page 3d, Item (6)(a)(1), please clarify whether "the maximum allowable amount established by the Department" refers to a fixed rate that providers would receive or does it refer to a range of the rates that providers can be paid up to the ceiling of the maximum rate?

**State's response:** The maximum allowable established by the State refers to a fixed rate.

6. The following Standard Funding Questions are being asked and should be answered in relation to FQHCs PPS payment made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA.

- a. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

**State's response:** SPA 11-030 does not apply to "FQHCs PPS payments" therefore, this question is not applicable to this SPA transmission.

- b. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following: (i) a complete list of the names of entities transferring or certifying funds; (ii) the operational nature of the entity (state, county, city, other); (iii) the total amounts transferred or certified by each entity; (iv) clarify whether the certifying or transferring

entity has general taxing authority: and, (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

**State's response:** Please refer to our response for Standard Funding Question in 6.a.

- c. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

**State's response:** Please refer to our response for Standard Funding Question in 6.a.

- d. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

**State's response:** Please refer to our response for Standard Funding Question in 6.a.

- e. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

**State's response:** Please refer to our response for Standard Funding Question in 6.a.

#### Coverage Questions:

Only prosthetic devices are covered under item 12c. This benefit category could encompass certain DME devices such as hearing aids that would meet the definition at 42 CFR 440.120(c) but would not include non-prosthetic DME devices such as oxygen tanks or enteral formula which are covered under the home health benefit for all Medicaid eligibles as explained above. Therefore, in view of the fact that these services 1) are covered under the home health benefit and 2) non-prosthetic services are not covered in 12c, the State should withdraw the following pages: Att: 3.1-A/B page 5 (preprint pages cannot be revised to re-define the 12c benefit description), and Att. 3.1-A/B page 18 and 18a.

**State's response:** The State is withdrawing pages Attachment 3.1-A page 5, Attachment 3.1-B pages 4 and 5, and Limitations on Attachment 3.1-A/3.1-B, pages 18 and 18a.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE: California

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REIMBURSEMENT METHODOLOGY FOR HEARING AID SERVICES

- (1) Reimbursement for hearing aid services as specified in the State Plan, Attachment 3.1-A entitled, "Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy" and in Attachment 3.1-B entitled, "Amount, Duration and Scope of Services Provided to Medically Needy Groups," item 12c., entitled, "Prosthetic devices and hearing aids," will be subject to the following limitations:
  - (a) The maximum reimbursement rate for hearing aids shall not exceed the lesser of the following:
    - (1) The maximum allowable amount established by the Department of Health Care Services (Department).
    - (2) The one-unit wholesale cost, plus a markup determined by the Department.
    - (3) The billed amount.
    - (4) The rate established by the Department's contracting program.
  - (b) The maximum reimbursement rate for hearing aid supplies and accessories shall not exceed the lesser of the following:
    - (1) The retail price.
    - (2) The wholesale cost, plus a markup determined by the Department.
    - (3) The billed amount.
    - (4) The rate established by the Department's contracting program.
  - (c) The maximum reimbursement rate for molds or inserts shall not exceed the lesser of the following:
    - (1) The maximum amount allowable established by the Department.
    - (2) The billed amount.
    - (3) The rate established by the Department's contracting program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE: California

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- (d) The maximum reimbursement for repairs, subsequent to the guarantee period, shall not exceed the lesser of the following:
- (1) The invoice cost plus a markup determined by the Department.
  - (2) The billed amount.
  - (3) The rate established by the Department's contracting program.
- (2) Hearing aid services, as specified in the State Plan, Attachment 3.1-A entitled, "Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy" and Attachment 3.1-B entitled, "Amount, Duration and Scope of Services Provided to Medically Needy Groups," item 12c., entitled "Prosthetic devices and hearing aids," are subject to a "benefit cap amount" of \$1,510. The "benefit cap amount" is the maximum amount of Medi-Cal coverage for hearing aid services for each beneficiary, for each fiscal year, as specified in California Welfare and Institutions Code section 14131.05 (as in effect on November 1, 2011).

Among the exceptions set forth in California law, the hearing aid "benefit cap amount" does not apply to the following:

- (a) Replacement of hearing aids that are lost, stolen, or irreparably damaged due to circumstances beyond the beneficiary's control.
  - (b) Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy.
  - (c) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program.
- (3) The State Agency's rates for the services listed in this segment of the State Plan were posted as of May 15, 2013, and are effective for dates of service on or after that date. The rates for these services are posted on the Medi-Cal Rates website at: <http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
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REIMBURSEMENT METHODOLOGY FOR ENTERAL FORMULAE

- (1) Reimbursement for enteral formulae, in accordance with California Welfare and Institutions Code section 14105.85, and as described in the State Plan Limitations in Attachment 3.1-A entitled, "Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy," and Attachment 3.1-B entitled, "Amount, Duration and Scope of Services Provided to Medically Needy Groups," will be based on the estimated acquisition cost for that product plus a percentage markup determined by the department.
  
- (2) The State Agency's rates for the services listed in this section were posted as of May 15, 2013, and are effective for dates of service on or after that date. The rates for these services are posted on the Medi-Cal Rates website at: <http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp>.

## STATE PLAN CHART

(Note: This chart is an overview only)

Limitations on Attachment 3.1-A

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
7c.2	Durable medical equipment	<p>Covered when prescribed by a licensed physician and reviewed annually.</p> <p>DME commonly used in providing SNF and ICF level of care is not separately billable.</p> <p>Common household items are not covered.</p>	<p>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.</p>
7c.3	Hearing aids	<p>Refer to Type of Service "12c Prosthetic and orthotic appliances, and hearing aids."</p>	<p>Refer to Type of Service "12c Prosthetic and orthotic appliances, and hearing aids."</p>
7c.4	Enteral Formulae	<p>Covered only when supplied by a pharmacy provider upon the prescription of a licensed physician within the scope of his or her practice.</p> <p>Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable.</p> <p>Common household items (food) are not covered.</p>	<p>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.</p> <p>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.</p>

\* Prior authorization is not required for emergency services.

\*\* Coverage is limited to medically necessary services.

TN 11-030  
Supersedes  
TN 11-012

Approval date: \_\_\_\_\_

Effective date: 11/1/2011