

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**

December 15, 2016

Mari Cantwell  
Chief Deputy Director, Health Care Programs  
California Department of Health Care Services  
P.O. Box 997413, MS 0000  
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) CA 16-018, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2016. This amendment makes technical revisions to update the home health section of the state plan to align with regulatory updates to Title 42 CFR 440.70.

The effective date of this SPA is July 1, 2016. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Limitations on Attachment 3.1-A, pages 12b and 14
- Limitations on Attachment 3.1-B, pages 12b and 14

Please note that the final Home Health rule was published on February 2, 2016 and went into effect July 1, 2016. The regulation provides a federal definition for medical supplies, equipment and appliances. Items previously not covered under the state plan may now need to be covered under the mandatory home health benefit. If the state needs to seek legislative approval to implement the new definitions, the state has up to one year to come into compliance, if their legislature has met in that year (i.e., July 2017) or 2 years to come into compliance (i.e., July 2018). At that time items and services that meet the criteria for coverage under the home health benefit must be covered according to home health coverage parameters. To ensure full coverage for medical equipment and appliances, to the extent that there is overlap in coverage with another benefit, states must nevertheless provide for the coverage of these items under the mandatory home health benefit for all populations.

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at [Cheryl.Young@cms.hhs.gov](mailto:Cheryl.Young@cms.hhs.gov).

Sincerely,

/s/

Henrietta Sam-Louie  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Cynthia Owens, California Department of Health Care Services (DHCS)  
Jim Elliott, DHCS  
Wendy Ly, DHCS  
Nathaniel Emery, DHCS

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**SPA 16-018**

2. STATE  
CA

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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  
July 1, 2016

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:  
SSA Section 1905(a) (7); 42 CFR 440.70

7. FEDERAL BUDGET IMPACT:  
a. FFY 2016 \$0  
b. FFY 2017 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Limitations on Attachment 3.1-A, Page 12b  
Limitations on Attachment 3.1-B, Page 12b  
Limitations on Attachment 3.1-A, Page 14  
Limitations on Attachment 3.1-B, Page 14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):  
  
Limitations on Attachment 3.1-A, pages 12b and 14  
Limitations on Attachment 3.1-B, pages 12b and 14

10. SUBJECT OF AMENDMENT:  
Adds the face-to-face requirement to durable medical equipment (DME) in accordance with Title 42 CFR 440.70.

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.

**ORIGINAL SIGNED**

16. RETURN TO:

**Department of Health Care Services  
Attn: State Plan Coordinator  
1501 Capitol Avenue, MS 4506  
P.O. Box 997417  
Sacramento, CA 95899-7417**

14. TITLE:  
**Chief Deputy Director  
Health Care Programs  
State Medicaid Director**

15. DATE SUBMITTED:  
**SEP 30 2016**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:

**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

**STATE PLAN CHART**

| TYPE OF SERVICES  | PROGRAM COVERAGE**   | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*   |
|---|--|--|
| <p>7. Home Health Services</p> <p>Home health agency services including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.</p> | <p>Home health services are covered if furnished by a home health agency that meets the conditions of participation for Medicare. Services are ordered by a physician as part of a written plan of care that the physician reviews every 60 days. Home health services include the following services:</p> <ol style="list-style-type: none"> <li>1. Skilled nursing services as provided by a nurse licensed by the state.</li> <li>2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110.</li> <li>3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110.</li> <li>4. Speech therapy services as provided by a speech therapist or speech pathologist licensed by the state and in accordance with 42 CFR 440.110.</li> <li>5. Home health aide services provided by a Home Health Agency.</li> </ol> |  |
| <p>7a. Home health nursing and<br/>7b. Home health aide services</p>  | <p>Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place.</p> <p>Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/IID. Services must be medically necessary.</p>   | <p>One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. All additional services and evaluations require prior authorization.</p> |

\*Prior authorization is not required for emergency services.

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

**STATE PLAN CHART**

| TYPE OF SERVICES               | PROGRAM COVERAGE**   | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*  |
|--------------------------------|--|---|
| 7c.2 Durable medical equipment | <p>Covered after a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist or a physician assistant when prescribed by a licensed physician and reviewed annually, in accordance with 42 CFR 440.70.</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> |

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