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

July 23, 2014

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) 11-030. SPA 11-030 was submitted to my office on December 7, 2011 in response to CMS' companion letter for California SPA 11-012. This SPA serves to clarify coverage provisions related to Durable Medical Equipment, and reimbursement provisions related to hearing aids.

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

- Limitations on Attachment 3.1-A, page 14
- Limitations on Attachment 3.1-B, page 14
- Attachment 4.19-B, pages 3i, 3i.1, 3i.2, 3j

If you have any questions, please contact Tom Schenck by phone at (415) 744-3589 or by email at Tom.Schenck@cms.hhs.gov.

Sincerely,

ORIGINAL SIGNED

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Connie Florez, California Department of Health Care Services
Nate Emery, 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: **11-030**

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 2012-13 **$0**
b. FFY 2013-14 **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 3i, 3i.1, 3i.2, and 3j
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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, page 14
Limitations on Attachment 3.1-B, page 14

10. SUBJECT OF AMENDMENT:

Reimbursement methodology for hearing aids, durable medical equipment and enteral formulae.

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

Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 6/17/14

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: 6/19/2014

18. DATE APPROVED: July 23, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/1/2011

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Hye Sun Lee

22. TITLE: Associate Regional Administrator

23. REMARKS:

This updated HCFA 179, submitted 6/7/14 (see box 15) replaces the original HCFA 179 (included as part of this package), that was submitted on 12/7/11. The original submittal date secured the approved effective date of 11/1/11. (TS)

FORM HCFA-179 (07-92)

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

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

1. TRANSMITTAL NUMBER: **11-030**

2. STATE: California

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

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 2012-13 $0
b. FFY 2013-14 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Page 5
Attachment 3.1-B, Page 4
Attachment 3.1-B, Page 5
Limitations on Attachment 3.1-A, Page 14
Limitations on Attachment 3.1-B, Page 14
Limitations on Attachment 3.1-A, Page 18
Limitations on Attachment 3.1-A, Page 18a
Limitations on Attachment 3.1-B, Page 18
Limitations on Attachment 3.1-B, Page 18a
Attachment 4.19-B, Page 3a
Attachment 4.19-B, Page 3d
Attachment 4.19-B, Page 3d.1
Attachment 4.19-B, Page 3g

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A, Page 5
Attachment 3.1-B, Page 4
Attachment 3.1-B, Page 5
Limitations on Attachment 3.1-A, Page 14
Limitations on Attachment 3.1-B, Page 14
Limitations on Attachment 3.1-A, Page 18
Limitations on Attachment 3.1-A, Page 18a
Limitations on Attachment 3.1-B, Page 18
Limitations on Attachment 3.1-B, Page 18a
Attachment 4.19-B, Page 3a
Attachment 4.19-B, Page 3d

10. SUBJECT OF AMENDMENT:

Clarifies prescription of durable medical equipment and payment methodologies for hearing aid services, enteral formulae, and durable medical equipment.

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

Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 12/7/11

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:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
7c.2	Durable medical equipment	Covered when prescribed by a licensed physician and reviewed annually. 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 physician 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

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* Prior authorization is not required for emergency services.
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: California

REIMBURSEMENT METHODOLOGY FOR HEARING AID SERVICES

(1) Definitions:

(a) Billed Amount: Includes actual product cost and related provider costs that include, but are not limited to, shipping, handling storage, and delivery.

(b) Retail Price: The usual and customary price charged to consumers for a particular product or service.

(c) Wholesale Cost: The unit price, or "the single unit" price as identified in the manufacturer's wholesale catalog, not including taxes, rebates and discounts.

(2) 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 reimbursement rate for hearing aids shall be the lowest 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.

(b) The reimbursement rate for hearing aid supplies and accessories shall be the lowest of the following:

(1) The retail price.
(2) The wholesale cost, plus a markup determined by the Department.
(3) The billed amount.

(c) The reimbursement rate for molds or inserts shall be the lower of the following:

(1) The maximum amount allowable established by the Department.
(2) The billed amount.

(d) The reimbursement for repairs, subsequent to the guarantee period, shall be the lower of the following:

(1) The invoice cost plus a markup determined by the Department.
(2) The billed amount.

(3) 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.

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

(4) The State Agency's rates for the services, as discussed on pages 3i and 3i.1, 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
STATE: California

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.