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State/Territory Name: California

State Plan Amendment (SPA) #: 13-014

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

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

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

NOV 07 2013

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 13-014. SPA 13-014 was submitted to my office on March 28, 2014 to comply with Section 4106 of the ACA, which establishes a one percentage point increase in the federal medical assistance percentage (FMAP) for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and clinical preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF).

The effective date of this SPA is January 1, 2013. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 3.1-A, pages 18 and 18a
- Attachment 3.1-B, pages 5, 18 and 18a
- Attachment 4.18-A, pages 1 and 3
- Attachment 4.18-C, pages 1 and 3

If you have any questions, please contact Tyler Sadwith by phone at (415) 744-3563 or by email at Tyler.Sadwith@cms.hhs.gov.

Sincerely,

/s/

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

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

1. TRANSMITTAL NUMBER: SPA 13-014	2. STATE California
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE January 1, 2013	

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

5. TYPE OF PLAN MATERIAL (*Check One*):

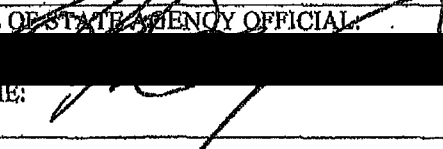
- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)), Section 4106(b) of the Affordable Care Act	7. FEDERAL BUDGET IMPACT: a. FFY 2013 (1/1/13 - 9/30/2013) \$16,388,164 b. FFY 2014 (10/1/13 - 9/30/2014) \$21,850,885
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-B, page 5 Attachment 4.18-A, page 1 and page 3 Attachment 4.18-C, page 1 and page 3 Limitations on Attachment 3.1-A, page 18 and page 18a Limitations on Attachment 3.1-B, page 18 and page 18a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-B, page 5 Attachment 4.18-A, page 1 and page 3 Attachment 4.18-C, page 1 and page 3 Limitations on Attachment 3.1-A, page 18 and page 18a Limitations on Attachment 3.1-B, page 18 and page 18a

10. SUBJECT OF AMENDMENT:
**To implement the Affordable Care Act Section 4106, to cover preventive services and vaccines in accordance with the
United States Preventive Services Task Force and the Advisory Committee on Immunization Practices.**

11. GOVERNOR'S REVIEW (*Check One*):
 GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED The Governor's Office does not
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: 

13. TYPED NAME:
Toby Douglas


14. TITLE:
Director

15. DATE SUBMITTED: **MAR 28 2013**

16. RETURN TO:

**Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 713.26
P.O. Box 997417
Sacramento, CA 95899-7417**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/28/2013	18. DATE APPROVED: NOV 07 2013
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/2013	SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Gloria Nagle, Ph.D. MPA	TITLE: Associate Regional Administrator

23. REMARKS:

STATE PLAN CHART

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.

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.

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 beneficiaries are exempted from the cap:

- Pregnant women, if hearing aids are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy.
- Individual who is an eligible beneficiary of the Early and Periodic Screening Diagnosis and Treatment Program.

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

TN No. 13-014
Supersedes
TN No. 11-012

NOV 07 2013

Approval Date: _____

Effective Date: 1/1/2013

STATE PLAN CHART

TYPE OF SERVICE

PROGRAM COVERAGE**

PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*

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 their pregnancy.
2. Individual who is an eligible beneficiary of the Early and Periodic Screening Diagnosis and Treatment Program.

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 EPSTD program

13b Screening services

Covered under this state plan only for EPSTD program

13c Preventive services

Covered for all preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). Preventive services are provided and covered by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan.

Prior authorization is not required and services are exempt from cost sharing in accordance with ACA Section 4106.

The State assures the availability of documentation to support the claiming of federal reimbursement for these services.

The State assures that the benefit package will be updated as changes are made to USPSTF and ACIP recommendations, and that the State will update the coverage and billing codes to comply with these revisions.

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

TN No. 13-014
Supersedes
TN No. 11-012

Approval Date: **NOV 07 2013**

Effective Date: 1/12013

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS

c. Prosthetic devices and hearing aids.

Provided No limitations With limitations

d. Eye Glasses.

Provided No limitations With limitations

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

a. Diagnostics 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 physician as having a substance-related disorder. (See Supplements 1, 2, and 3 to Attachment 3.1-B)

Provided No limitations With limitations

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

a. Inpatient hospital services

Provided No limitations With limitations

b. Skilled nursing facility services

Provided No limitations With limitations

*Description provided on attachment.

STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
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12b. Dentures	See 10.	See 10.
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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.
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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 beneficiaries are exempted from the cap:

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- Individual who is an eligible beneficiary of the Early and Periodic Screening Diagnosis and Treatment Program.

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STATE PLAN CHART

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
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 their pregnancy. 2. Individual who is an eligible beneficiary of the Early and Periodic Screening Diagnosis and Treatment Program.	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 EPSTD program.	
13b Screening services	Covered under this state plan only for EPSTD program.	
13c Preventive services	Covered for all preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). Preventive services are provided and covered by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan.	Prior authorization is not required and services are exempt from cost sharing in accordance with ACA Section 4106. The State assures the availability of documentation to support the claiming of federal reimbursement for these services. The State assures that the benefit package will be updated as changes are made to USPSTF and ACIP recommendations, and that the State will update the coverage and billing codes to comply with these revisions.

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

NOV 07 2013

TN No. 13-014
Supersedes
TN No. 11-012

Approval Date: _____

Effective Date: 1/1/2013

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

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge Deduct. Coins. Copay.	Amount of Basis for Determination
Clinic	X	\$1 per visit
Surgical center	X	\$1 per visit
Optometric	X	\$1 per outpatient visit
Chiropractic	X	\$1 per outpatient visit
Psychology	X	\$1 per outpatient visit
Podiatric	X	\$1 per outpatient visit
Occupational therapy	X	\$1 per outpatient visit
Physical therapy	X	\$1 per outpatient visit
Speech therapy	X	\$1 per outpatient visit
Audiology	X	\$1 per outpatient visit
Acupuncture	X	\$1 per outpatient visit
Drug Prescriptions	X	\$1 per outpatient drug prescription
Dental	X	\$1 per outpatient dental visit
Nonemergency services in an emergency room	X	\$5 per visit (average payment for nonemergency services in an emergency room is greater than \$50) All other amounts besides nonemergency services in an emergency room that meet the definition of nominal.

Exceptions:

1. Any service for which the State payment is \$10 or less.
2. Any family planning service.
3. Any service provided to a person under age 19.
4. Any service furnished to a pregnant women, if the service relates to the pregnancy or to any other medical condition which may complicate the pregnancy, including counseling and pharmacotherapy for cessation of tobacco use.
5. Any service provided to an individual who is an inpatient in a hospital, long-term care facility or other medical institution who is required to spend all but a minimal amount of his income required for personal needs towards the cost of care.
6. Any children under 21 living in boarding homes or institutions for foster care.
7. Any individual who is currently or has previously used services provided by an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) in any state and any American Indian/Alaskan Native that have received services through referral under contract health services.
8. Any preventive services and vaccines in accordance with the Affordable Care Act Section 4106.

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

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Medi-Cal will exempt all applicable beneficiary groups from cost sharing by the following:

The county eligibility worker will verify that the beneficiary is part of an exempted group, then insert an "exemption indicator" in the cost sharing field of the Medi-Cal Eligibility Data System (MEDS). The indicator in MEDS will translate into a message displayed at the time the provider checks the beneficiary's Medi-Cal eligibility status. Providers will be alerted that the beneficiary is exempt from cost sharing, and that cost sharing is not permissible.

Also, the State will instruct providers via provider bulletins, and the Medi-Cal *Newsflash* of covered services, including services applicable to the Affordable Care Act, Section 4106, which are not subject to copayment and of those individuals who are exempt from copayments. The State will send notices to beneficiaries to inform them of the services and beneficiaries that are exempt from cost sharing and those services/conditions under which copayments are enforceable.

Section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447 exempts American Indian/Alaskan Native (AI/ANs) from cost sharing, if they have received an item or service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services.

Effective January 1, 2014, the State will implement the above described MEDS system changes for exempting AI/ANs from cost sharing. If the AI/AN self attests that he/she has received a service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services, the AI/AN is exempt from cost sharing. If the AI/AN does not provide self-attestation, then they must submit a letter to the county on I/T/U letterhead that exempts the AI/AN under section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447. The county will, upon receipt of the letter or self-attestation, submit a transaction with an indicator to identify AI/ANs on the State's MEDS. This indicator along with the premium aid code identifies the AI/AN as exempt from cost sharing.

- E. Cumulative maximums on charges:

- State policy does not provide for cumulative maximums.
 Cumulative maximums have been established as described below.

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

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge Deduct. Coins. Copay.	Amount of Basis for Determination
Physician	X	\$1 per visit
Clinic/Outpatient	X	\$1 per visit
Surgical center	X	\$1 per visit
Optometric	X	\$1 per outpatient visit
Chiropractic	X	\$1 per outpatient visit
Psychology	X	\$1 per outpatient visit
Podiatric	X	\$1 per outpatient visit
Occupational therapy	X	\$1 per outpatient visit
Physical therapy	X	\$1 per outpatient visit
Speech therapy	X	\$1 per outpatient visit
Audiology	X	\$1 per outpatient visit
Acupuncture	X	\$1 per outpatient visit
Drug Prescriptions	X	\$1 per outpatient drug prescription
Dental	X	\$1 per outpatient dental visit
Nonemergency services in an emergency room	X	\$5 per visit (average payment for nonemergency services in an emergency room is greater than \$50) All other amounts besides nonemergency services in an emergency room that meet the definition of nominal.

Exceptions:

1. Any service for which the State payment is \$10 or less.
2. Any family planning service.
3. Any service provided to a person under age 19.
4. Any service furnished to a pregnant women, if the service relates to the pregnancy or to any other medical condition which may complicate the pregnancy, including counseling and pharmacotherapy for cessation of tobacco use.
5. Any service provided to an individual who is an inpatient in a hospital, long-term care facility or other medical institution who is required to spend all but a minimal amount of his income required for personal needs towards the cost of care.
6. Any children under 21 living in boarding homes or institutions for foster care.
7. Any individual who is currently or has previously used services provided by an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) in any state and any American Indian/Alaskan Native that have received services through referral under contract health services.
8. Any preventive services and vaccines in accordance with the Affordable Care Act Section 4106.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

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Also, the State will instruct providers via provider bulletins, and the Medi-Cal *Newsflash* of covered services, including services applicable to the Affordable Care Act, Section 4106, which are not subject to copayment and of those individuals who are exempt from copayments. The State will send notices to beneficiaries to inform them of the services and beneficiaries that are exempt from cost sharing and those services/conditions under which copayments are enforceable.

Section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447 exempts American Indian/Alaskan Native (AI/ANs) from cost sharing, if they have received an item or service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services.

Effective January 1, 2014, the State will implement the above described MEDS system changes for exempting AI/ANs from cost sharing. If the AI/AN self attests that he/she has received a service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services, the AI/AN is exempt from cost sharing. If the AI/AN does not provide self-attestation, then they must submit a letter to the county on I/T/U letterhead that exempts the AI/AN under section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447. The county will, upon receipt of the letter or self-attestation, submit a transaction with an indicator to identify AI/ANs on the State's MEDS. This indicator along with the premium aid code identifies the AI/AN as exempt from cost sharing.

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