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State/Territory Name: California

State Plan Amendment (SPA) #: 17-012

This file contains the following documents in the order listed:

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

October 23, 2017

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 17-012, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on August 17, 2017. This SPA responds to the companion letter for SPA 16-018 to comply with 42 CFR 440.70. This SPA will add the face-to-face encounter requirement prior to the initiation of services by a home health agency and remove all references to "licensed practitioner" ordering home health services, including medical supplies, equipment, and appliances, and instead require a physician to order these items for beneficiaries. This SPA also updates the dollar amount required for a Treatment Authorization Request (TAR) for durable medical equipment.

The effective date of this SPA is July 1, 2017. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Limitations on Attachment 3.1-A, pages 12b, 13 and 14
- Limitations on Attachment 3.1-B, pages 12b, 13 and 14

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at 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
Nathaniel Emery, DHCS

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: **17-012**

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
July 1, 2017

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. FY 2017 $0
b. FY 2018 $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 13
Limitations on Attachment 3.1-B, Page 13
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 12b
Limitations on Attachment 3.1-B, Page 12b
Limitations on Attachment 3.1-A, Page 13
Limitations on Attachment 3.1-B, Page 13
Limitations on Attachment 3.1-A, Page 14
Limitations on Attachment 3.1-B, Page 14

10. SUBJECT OF AMENDMENT:
Home health services and medical supplies

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:
[redacted]

13. TYPED NAME:
Mari Cantwell

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

15. DATE SUBMITTED:
August 17, 2017

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 17, 2017

18. DATE APPROVED:
October 23, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Henrietta Sam-Louie

22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations

23. REMARKS:

Box 15: CMS added SPA submission date as a pen and ink change per state approval via email dated 10/17/17.

STATE PLAN CHART

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7. Home Health Services 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.	Home health services are covered after a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist, physician assistant or a certified nurse midwife, in accordance with 42 CFR 440.70, when 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: 1. Skilled nursing services as provided by a nurse licensed by the state. 2. Physical therapy services as provided by a physical therapist licensed by the state and in accordance with 42 CFR 440.110. 3. Occupational therapy services as provided by an occupational therapist licensed by the state and in accordance with 42 CFR 440.110. 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. 5. Home health aide services provided by a Home Health Agency.	
7a. Home health nursing and 7b. Home health aide services	Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place. Services are provided at a participant's residence which does not include a hospital, nursing facility or ICF/IID. Services must be medically necessary.	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.

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

STATE PLAN CHART

(Note: This chart is an overview only)

TYPE OF SERVICE	PROGRAM COVERAGE***	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1 Medical supplies	As prescribed by a physician within the scope of his or her practice. Common household items, supplies not primarily medical in nature, and articles of clothing are not covered. Medical supplies provided in renal dialysis centers are included in the all-inclusive rate and are not separately billable. Medical supplies commonly used in providing SNF and ICF level of care are not separately billable.	Prior authorization is required for suppliers listed in the Medical Supplies Formulary. Certain items require authorization unless used for the conditions specified in the Medical Supplies Formulary.
	Blood and blood derivatives are covered when ordered by a physician or dentist.	Prior authorization is not required. Certification that voluntary blood donations cannot be obtained is required from blood banks supplying the blood or facility where transfusion is given.

* 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*
7c.2 Durable medical equipment	Covered after a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist or a physican assistant when prescribed by a physician and reviewed annually, in accordance with 42 CFR 440.70. 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 $250, 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 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.

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