Table of Contents

State/Territory Name: California

State Plan Amendment (SPA) #: 15-036

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

January 7, 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) 15-036. SPA 15-036 was submitted to my office on November 25, 2015 to provide technical updates for prosthetic and orthotic appliances and hearing aids to reflect that these appliances are covered when prescribed by a physician or other licensed practitioner, instead of physician or podiatrist, to conform with 42 CFR 440.120. This SPA also adds language that the hearing aid cap can be "exceeded based on medical necessity" to be consistent with the state's Alternative Benefit Plan (ABP) and current policy.

The effective date of this SPA is October 1, 2015. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Limitations to Attachment 3.1-A, page 18
- Limitations to Attachment 3.1-B, page 18

If you have any questions, please contact Cheryl Young by phone at (415) 744-3598 or by email at Cheryl.Young@cms.hhs.gov.

Sincerely,

/s/

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

Enclosure

cc: Laurie Weaver, California Department of Health Care Services
Nathaniel 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: **15-036**

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
October 1, 2015

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:
Social Security Act, Section 1905 (a)(12)
42 CFR 440.120

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 18, item 12c
Limitations on Attachment 3.1-B, page 18, item 12c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Limitations on Attachment 3.1-A , page 18, item 12c
Limitations on Attachment 3.1-B, page 18, item 12c

10. SUBJECT OF AMENDMENT:
Technical amendment to update information and language regarding prosthetic and orthotic appliances and hearing aids.

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: NOV 23 2015

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:
November 25, 2015

18. DATE APPROVED:
January 7, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Henrietta Sam-Louie

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

23. REMARKS:

FORM HCFA-179 (07-92)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b. Dentures	See 10.	See 10.
12c. Prosthetic and orthotic applicances, and hearing aids	Prosthetic and orthotic appliances are covered when prescribed by a physician or other licensed practitioner within their scope of practice. 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. 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, although this limit can be exceeded based on medical necessity through prior authorization. Hearing aid benefits include hearing aids and hearing aid supplies and accessories. The following beneficiaries are exempt 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. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment Program.	Prior authorization is required. 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.

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

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