



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

August 26, 2013

Gloria Nagle, PhD, MPA
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RESPONSE TO REQUEST FOR ADDITIONAL INFORMATION FOR STATE PLAN
AMENDMENT 13-014

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting its response to the June 25, 2013, Request for Additional Information (RAI) for State Plan Amendment (SPA) 13-014. DHCS originally submitted SPA 13-014 on March 28, 2013, to recognize clinical preventive services and adult vaccine services and to establish a (1) one percent point increase in federal medical assistance percentage (FMAP) for expenditures.

DHCS has been working cooperatively with Region IX staff of the Centers for Medicare & Medicaid Services (CMS) on this SPA and on June 14, 2013, DHCS sent responses to CMS's informal comments and request for additional State Plan pages. DHCS responses to the RAI and informal comments are included with this letter, as well as the following updated SPA pages:

- Attachment 4.18-A, page 3, clean and redline versions
- Attachment 4.18-C, page 3, clean and redline versions
- Limitations on Attachment 3.1-A, page 18, clean and redline versions
- Limitations on Attachment 3.1-B, page 18, clean and redline versions

I want to thank your staff for the open dialogue during the SPA review process. If you have any questions regarding the information provided, please contact, Laurie Weaver, Chief, Benefits Division, at (916) 552-9400.

Sincerely,

ORIGINAL DOCUMENT SIGNED BY:

Toby Douglas
Director

Enclosures

cc: Donald A. Novo
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REQUEST FOR ADDITIONAL INFORMATION
STATE PLAN AMENDMENT 13-014
JUNE 25, 2013

General

1. HCFA 179, Box 7: In its responses to CMS' informal questions, DHCS asked that CMS make a pen and ink change to Box 7, item a, to indicate a Federal budget impact of \$2.5 million for Federal fiscal year (FFY) 2013-2014, and to strike item b. However, CMS requires that DHCS provide estimates for the upcoming two Federal fiscal years. Please provide independent estimates for the Federal budget impact for FFY 2013 (1/1/13 - 9/30/2013), and FFY 2014 (10/1/13 - 9/30/14).

DHCS RESPONSE: Per CMS guidance DHCS will submit separately, the estimates for the federal budget impact for fiscal years:

- a. FFY 2013 \$
- b. FFY 2014 \$

Coverage

2. The 6th paragraph of page 18 on both Attachments 3.1-A and 3.1-B states that "Hearing aid benefits are subject to a \$1,510 maximum cap per beneficiary per fiscal year." It then goes on to indicate that covered hearing aid benefits are provided to pregnant women and EPSDT beneficiaries. However, the language does not exempt these beneficiaries from the annual monetary cap. Please amend the language on these pages to ensure that pregnant women and EPSDT individuals are exempt from any annual dollar limitation on medically necessary hearing aid benefits.

DHCS RESPONSE: The State made the requested edits to the Limitations on Attachment 3.1-A and –B to reflect these exempted populations.

Cost-Sharing

3. On page 3, the state indicates that if an AI/AN attests to being eligible to receive, or has received a service from an I/T/U or through CHS referral, they would exempt from cost sharing. However, being "eligible" for such services only exempts a beneficiary from premiums, not cost sharing. Please revise or remove the language to be clear that "eligible for or received" is for the premium exemption, and "received" is for the cost sharing exemption.

DHCS RESPONSE: The State removed the language "is eligible to receive or" from the narrative on page 3 of the Attachments 4.18-A and 4.18–C.

4. On page 3 of both Attachments 4.18-A and 4.18-C, the 2nd paragraph of the language related to the AI/AN exemption indicates "The State is in the process of developing a means for exempting AI/ANs from cost-sharing." The remainder of the

2nd paragraph goes on to detail a process through which AI/AN beneficiaries either self-attest, or 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 (ACA). This exemption is then indicated in the Medi-Cal Eligibility Data System (MEDS), such that a provider can query to determine whether an individual may be charged cost-sharing. Regarding the described process:

- a. Please clarify if this process is under development, or if this process is currently in place.

DHCS RESPONSE: The Medi-Cal Eligibility Data System (MEDS) system changes are under development.

- b. If this process is still under development, and the state is currently exempting AI/ANs based on race, please add a future effective date into the State Plan to indicate when the new process will begin.

DHCS RESPONSE: The new MEDS cost sharing “exemption indicator” will be in place by January 1, 2014, and the State has revised page 3 of Attachments 4.18-A and 4.18-C to include this effective date.

- c. If it is already in effect, please clarify if this process is specific to AI/AN beneficiaries, or if this process applies to all of the exempted beneficiary groups and services required by 1916(a) of the Act and listed on page of Attachments 4.18-A and 4.18-B (beneficiaries under 19, etc.).

DHCS RESPONSE: The process is not in effect. However, the self-attestation or letterhead exemption process is specific to the AI/AN beneficiaries. Please see the revised Attachments 4.18-A and 4.18-C, page 3.

- d. If the described process is specific to AI/AN beneficiaries, please describe the process in place (or under development) to preclude all other exempted beneficiaries from being charged cost-sharing.

DHCS RESPONSE: The described self-attestation or letterhead exemption process is specific to AI/AN beneficiaries. DHCS has a slightly more streamlined process to preclude all other exempted beneficiaries from being charged cost-sharing. The process is the same as the process specific to AI/AN beneficiaries, except it does not entail a self-attestation or letterhead. It only entails the county eligibility worker verifying that the beneficiary is part of an exempted group. After that initial verification, the MEDS process for AI/AN beneficiaries and other exempted beneficiaries is identical.

In addition, DHCS will implement a separate process to preclude cost sharing for preventive services and vaccines for all beneficiaries. DHCS will send to all beneficiaries a notice to explain to them that they do not have any cost sharing (copayment) obligation for covered preventive services and vaccines. The notice will also inform beneficiaries that if they paid a copayment for these services on or after January 1, 2013, that they are entitled to a full refund of the copayment from the provider. In those cases where the provider is no longer in

business, beneficiaries will be instructed to use the established *Conlan* process, see information at http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx.

This process has been shown to be effective because a similar process was used to reimburse beneficiaries for overpayments made to providers related to the court order that resulted from the *Conlan* litigation. The notice will also be posted on the DHCS and Medi-Cal web sites with an instructional webinar.

DHCS will notify providers through the Medi-Cal monthly provider bulletin, Medi-Cal "*Newsflash*" and DHCS web sites, Medi-Cal provider manual, and amendments to the Medi-Cal managed care contracts. DHCS will also instruct providers to reimburse beneficiaries for any documented copayments for preventive services or vaccines that occurred on or after January 1, 2013.

5. The one percentage point FMAP increase made available through Section 4106 of the Affordable Care Act for expenditures for certain adult vaccines and clinical preventive services requires that these services be provided without cost-sharing. Please clarify how the State can ensure that no beneficiaries have been charged cost-sharing for a specified preventive service since 1/1/13. Specifically:

a. Please clarify whether, prior to 1/1/13, cost-sharing was allowable under the State Plan, regardless of the fact that a provider cannot deny services for non-payment, for the preventive and vaccine services specified by Section 4106 of the ACA. For example, could the \$1 physician copayment listed on page 1 of Attachments 4.18-A and 4.18-C have been charged for one of the specified preventive services?

1. If cost-sharing for these services was previously allowable, were providers educated that as of 1/1/13 cost-sharing must be waived for these preventive and vaccine services? If so, how and when was this requirement communicated to the providers?

DHCS RESPONSE: DHCS will notify providers of the provisions of ACA Section 4106, once SPA 13-014 is approved. Provider notifications will occur through the Medi-Cal monthly provider bulletin, Medi-Cal "*Newsflash*" and DHCS web sites, Medi-Cal provider manual, and amendments to the Medi-Cal managed care contracts. DHCS will also instruct providers to reimburse beneficiaries for any documented copayments for preventive services or vaccines that occurred on or after January 1, 2013. DHCS has posted SPA 13-014 on the DHCS web site for public and provider viewing.

DHCS will also send out a notice to all Medi-Cal beneficiaries to explain to them that they do not have any cost sharing (copayment) obligation for covered preventive services and vaccines. The notice will also inform beneficiaries that if they paid a copayment for preventive services and/or vaccines on or after January 1, 2013, that they are entitled to a full refund from the provider. The notice will also be posted on the DHCS and Medi-Cal web sites with an instructional webinar.

Also, Assembly Bill 82, Committee on Budget: Health, Chapter 23, Statutes of 2013, amended Welfare and Institutions Code §14134, SEC 65 to mandate no cost sharing for any preventive service in accordance with the United States Preventive Services Task Force and vaccines in accordance with the Advisory Committee on Immunization Practices.

2. If cost-sharing for these services was previously allowable, was the reimbursement rate paid, to the providers of these services reduced by the cost sharing amount specified in the state plan?

DHCS RESPONSE: The DHCS Fiscal Intermediary did not reduce Medi-Cal provider reimbursements.

- b. Regarding the cost-sharing exclusions contained in 42 CFR 447.53(b), page 3 of Attachments 4.18-A and 4.18-C states that "enforcement is accomplished by contacting individual providers when complaints of noncompliance are brought to the attention of the State agency." This is not a sufficient process to ensure that cost-sharing is not imposed on exempt individuals and services, including the preventive and vaccine services specified by Section 4106 of the Affordable Care Act. In order to enforce the exemptions listed on page 1 of Attachments 4.18-A and 4.18-C, does the State intend to utilize an indicator in MEDS, similar to the proposed process for implementing the Indian exemption? If not, please describe the process through which the cost-sharing exclusions will be enforced.

DHCS RESPONSE: Yes. DHCS is exploring a similar if not the same cost-sharing (copayment) "exemption indicator" in MEDS that will identify the exempted beneficiaries listed on page 1 of Attachment 4.18-A, and 4.18-C. Please see the revised Attachment 4.18-A and 4.18-C, page 3 that explains the cost-sharing exclusion process.

In addition, DHCS will conduct a vast notification process to instruct providers and beneficiaries on the cost sharing (copayment) exclusions, including the policies applicable to the ACA Section 4106. Further, beneficiaries will be sent a notice that explains the *Conlan* process and how to seek direct repayment from the Medi-Cal provider. This process has been shown to be effective because it is similar to the process used to reimburse beneficiaries for overpayments made to providers related to the court order that resulted from the *Conlan* litigation.

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	<p>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.</p> <p>Prosthetic eyes are covered when prescribed by a physician or other licensed practitioner performing within his or her scope of practice.</p> <p>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.</p> <p>Loaner aids, during repair periods covered under guarantee, are not covered. Replacement batteries are not covered.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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. 	<p>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.</p> <p>Prior authorization is required for prosthetic eyes and most prosthetic eye services.</p> <p>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.</p>

* [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: _____

Effective Date: 1/1/2013

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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
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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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