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Project Officer, Region IX  
Division of State Children's Health Insurance  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S2-01-16  
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Re: California Title XXI State Plan Amendment – Healthy Families Program (HFP)

- Family Contribution Increase
- Established Dental Benefit Cap
- Modified Vision Benefits
- Established Infrastructure to Wait List/Disenrollments
- Eliminated AIM Program 6-month residency requirement

Dear Mr. Silverman:

The State of California is resubmitting for your review and approval amendments to California's Title XXI State Plan. The amendments describe family contribution increases; new dental benefit cap; modified vision benefits; the infrastructure for wait list and Annual Eligibility Review (AER) disenrollments; and elimination of the AIM Program 6 month residency requirement. This resubmission addresses all questions in CMS' July 31, 2009, letter regarding the previous submission of this State Plan Amendment. Changes within the State Plan are in strike-out for deleted text and underline for new text format. Answers to certain CMS questions are addressed below.

**CMS Question 2:**

CMS questioned California's proposed dental cap effective July 1, 2009, when the Children's Health Insurance Program Reauthorization ACT of 2009 (CHIPRA) states that certain dental coverage must be provided by October 1, 2009.

California is aware and is waiting for CMS' direction on the definition for the required dental benefits. We have taken CMS' comment under advisement and California will continue to track the Dental requirement and CHIPRA implementation.

**CMS Question 3:**

CMS asked for confirmation whether California is referring to “mothers of unborn children” served through approved Title XXI coverage for the unborn. If so, CMS requested that the term “pregnant women” be replaced with “mothers of unborn children”.

In California’s SPA #12, submitted to CMS on June 29, 2005, and approved on March 28, 2006, CMS approved language describing the pregnant woman as “eligibles from confirmed pregnancy” and therefore we have included the previously approved SPA #12 language, which is consistent with California State Statute.

**CMS Question 4:**

CMS requested verification that individuals who are eligible for the California Public Employees’ Retirement System (CalPERS) Health Benefits Program are in fact State employees.

California verifies that some individuals eligible for the California Public Employees’ Retirement System Health Benefits Program (CalPERS) are California State Employees. The following individuals may also be eligible for CALPERS: Public Agency, School District, Legislators’, Judicial and Part-Time National Guard Employees.

**CMS Question 5:**

CMS requested California to indicate how it would identify and track individuals eligible for the CalPERS health benefit program whose employers contribute less than \$10 for dependent coverage.

California tracks individuals that are CalPERS eligible by reviewing submitted income documentation for employer insurance contributions for dependent coverage. Individuals whose documentation clearly indicates CalPERS dependent coverage with an employer contribution greater than \$10 will be determined ineligible for the HFP. The HFP will solicit clarification of the amount of employer contribution toward a dependent’s CalPERS benefits in the event this is unclear.

**CMS Questions 6 and 11:**

CMS noted that the State crossed out language regarding audits to verify income and citizenship eligibility via the IEVS (Income Eligibility Verification System) and SAVE (Systematic Alien Verification XXX) and requested confirmation that California continues to utilize a systematic audit process to verify income and citizenship, and confirmation that the State’s income and citizenship verification processes are compliant with State program administration requirements outlined in 42 CFR 457.910.

California confirms that it utilizes a thorough process with our Administrative Vendor for verifying income and citizenship eligibility. This includes requiring income and citizenship documentation at the initial application and requiring income documentation during the annual renewal process. In utilizing this process, an eligibility determination is based on a

point in time. California complies with State Administrative processes and requires actual documentation from families. California has a high standard of quality in eligibility determination and associated liquidated damages if regulations are not met. California also has subsequent audit processes to assure that appropriate documentation was provided for an eligibility determination. As the Payment Error Rate Method (PERM) audit process indicated, California accuracy is exemplary and its separate CHIP error rate is less than 1%.

**CMS Question 7:**

CMS requested clarification of how California will notify CMS prior to implementation of a waiting list/disenrollment structure.

On July 16, 2009, Executive Director Lesley Cummings contacted Kathleen Farrell at CMS via email regarding a Waiting List for the Healthy Families Program, effective July 17, 2009. This waiting list was necessary due to a budget short fall and has since been ended, effective September 17, 2009.

**CMS Question 12:**

CMS notes that the State indicates that it enrolls certain individuals with employer coverage into the Access for Infants and Mother (AIM) program, but does not claim Federal Financial Participation (FFP) for these enrollees. CMS questioned how these individuals are identified and tracked so to ensure their costs are not claimed for FFP.

In California's SPA #7 (Section 2.3), submitted to CMS on April 1, 2003, and approved on June 10, 2004, California informed CMS that it would track the insured status of women enrolled in AIM and would not claim federal financial participation for those with other health coverage. The actual claims to the federal government are based on the data collected on the mother's insurance status from the AIM application. California only claims federal funds on 90% of AIM mothers.

**CMS Question 13 and 14:**

In CMS' letter to the MRMIB dated March 16, 1998, CMS indicated that it had concerns regarding the cost-sharing of the Family Value Package (FVP). CMS was concerned that it violated the cost sharing protections included in the Title XXI statute because some children would be liable for cost-sharing in excess of statutory limits; therefore, the FVP was never approved.

California will delete references to selling plans that are more expensive than the FVP, as this was never approved or implemented. Subscribers are responsible for tracking their co-payments made within each benefit year July 1 to June 30. When the subscriber notifies the health plan that the co-payment maximum of \$250 per subscriber has been reached, any co-payments for health care services received thereafter are waived until the next benefit year of coverage. The five-percent limit is virtually impossible for a family to exceed based on the annual co-payment maximum and the number of additional visits for services required, as shown in the income chart tables in Section 8.5.

CMS asked whether, if an HFP family chooses a higher priced health plan and reaches the 5% cost-sharing maximum, the State will begin paying the difference in premium between the higher and lower priced health plans; or whether California will require families to enroll in the lower priced health plan.

California's income charts, as shown in Section 8.5, are based on the highest income and premiums levels, providing descriptions demonstrating that it would be virtually impossible for a family to exceed the 5% annual maximum through co-payments. The subscriber is responsible for tracking the number of co-payments made per visit within each benefit year July 1 to June 30. When the subscriber notifies the health plan that the co-payment maximum of \$250 has been reached, any co-payment thereafter for health care services will be waived until the next benefit year of coverage. California's approach was previously discussed with CMS in detail and approved.

**CMS Question 15:**

CMS requested clarification whether California maintains two premium structures for the Access for Infants and Mothers (AIM) program, based on an enrollment before or after July 1, 2004. The CMS letter also instructs California to update the SPA to include only current cost sharing. CMS STC letter states that SPA should be updated to include only current cost sharing if there are no longer two different AIM premium structures.

The state maintains only one premium structure under AIM for participants enrolled on or after July 1, 2004. Reference to the premium structure for AIM participants enrolled prior to July 1, 2004, is only shown in the SPA as historical reference. The prior premium structure provided coverage to the AIM subscriber for prenatal care, labor and delivery, and sixty (60) days post partum care, and for their newborn for the first year of life. An additional \$100 covered the newborn for a second year. The current premium structure provides for coverage for the AIM subscriber for prenatal care, labor and delivery and sixty (60) days post partum care and the newborn now receives coverage through the HFP from the date of birth up to age 19.

**CMS Question 16:**

CMS requested California to update section 8.5 to specifically describe the method the State uses to track family cost-sharing to ensure it does not exceed the 5% cost-sharing maximum.

The premium level and the co-payment cap are below the five percent cost-sharing maximum, as indicated in California's income charts, as shown in Section 8.5, and it is virtually impossible to reach the five percent maximum with additional health, dental and vision visits. If the subscriber reaches this co-payment cap, the services will be waived until the next benefit year of coverage. California's approach was previously discussed with CMS in detail and approved.

**CMS Question 18:**

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CMS requested California update section 9.9.1 to describe its current process for active engaging Native American tribes.

This section accurately reflects California's current efforts to engage Indian Tribes.

**CMS Question 21:**

CMS questioned what would happen in a case the where a child has a serious or potentially life-threatening dental emergency, but has reached the annual dental benefit.

To the extent that dental services are appropriate under the child's health plan in addition to their dental plan, they will be provided. Otherwise services under the program will not be provided beyond the dental cap.

We are confident that we have addressed CMS' concerns and provided clarity where needed. If you have any questions, please do not hesitate to contact Mr. Ernesto A. Sanchez of my staff at (916) 327-6563 or email him at [esanchez@mrmib.ca.gov](mailto:esanchez@mrmib.ca.gov).

Sincerely,

Lesley Cummings  
Executive Director

Enclosures

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