STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

Alternative Premiums and Cost Sharing Changes

The following alternative premiums and cost sharing changes are imposed under section 1916A of the Social Security Act and 42 CFR 447.50 and 447.62 – 447.82. A state may select one or more options for cost sharing (including copayments, coinsurance, and deductibles) and premiums.

A. For groups of individuals with family income at or below 100 percent of the Federal Poverty Level (FPL):

1. Cost Sharing
   a. Amount of Cost Sharing
      i. _X_/ No cost sharing is imposed.
      ii. ___/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

2. Premiums
   a. Amount of Premiums
      No premiums may be imposed for individuals with family income at or below 100 percent of FPL.

B. For groups of individuals with family income above 100 percent, but at or below 150 percent of FPL:

1. Cost Sharing
   a. Amount of Cost Sharing
      i. _X_/ No cost sharing is imposed.
      ii. ___/ Nominal cost sharing is imposed under section 1916 of the Act (See Attachment 4.18-A and/or 4.18-C).
      iii. ___/ Alternative cost sharing is imposed under section 1916A of the Act as follows (specify the amounts of group and services (see below)):

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including monthly or quarterly period)
		Deductible	Coinsurance	Copayment	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

b. Limitations:
- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a _XX_ monthly or __ quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A (b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State: None

c. Enforcement

___/ Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

Regardless of whether the State elects the above option to permit providers to enforce the collection of cost sharing payments, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, the State's payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums
a. Amount of Premiums
No premiums may be imposed for individuals with family income above 100 percent of the FPL, but at or below 150 percent.

C. For groups of individuals with family income above 150 percent of the FPL:

1. Cost Sharing
a. Amount of Cost Sharing
i. X/ No cost sharing is imposed.
ii. __/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A page 1 and/or 4.18-C page 1.
iii. __/ Alternative cost sharing is imposed under section 1916A of the Act as follows (specify the amounts of group and services (see below)):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including monthly or quarterly period)
		Deductible	Coinsurance	Copayment	

b. Limitations:
- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a _X_ monthly or __ quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A(b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State: None

c. Enforcement
___/ Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

Regardless of whether the State elects the above option, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, the State's payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums
a. Amount of Premiums
i. __/ No premiums are imposed.
ii. _X/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

Group of Individuals including income level	Premium	*Method of Determining Family Income, if different than for eligibility (including monthly or quarterly period)
Optional targeted low-income children (OTLIC) ages 1 up to the month of their 19th birthday, who have family incomes above150 percent and up to and including 250 percent.	$13 per month 1 child $26 per month 2 children $39 per month 3 or more children	The methodology used for determining eligibility, includes, a disregard of income between 200 percent of the federal poverty level up to and including 250 percent of the federal poverty level. *The method of income determination changes January 1, 2014; at that time income disregards are no longer applicable due to implementation of the Affordable Care Act.

b. Limitation:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a X monthly or __ quarterly basis as specified by the State.
  - Premiums may not be imposed for the populations specified at section 1916A(b)(3)(A) of the Act and 42 CFR 447.66(a).
  - Additional limitations specified by the State:

Section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447 exempts American Indian/Alaskan Native (AI/ANs) from premiums and enrollment fees, if they are eligible to receive or 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.

The State is in the process of developing a means for exempting AI/ANs. California anticipates January 1, 2014 as the completion date for the development process to exempt AI/ANs from cost-sharing and premium payments. If the parent/guardian self attests that the AI/AN applying is eligible to receive or 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 will not have to pay premium payments. If the parent/guardian does not provide self-attestation, then the parent/guardian 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/aid code to identify AI/ANs on the State's Medi-Cal Eligibility Data System (MEDS). This indicator/aid code identifies the AI/AN as exempt from paying premiums or copays. The state's premium payment processor receives monthly files from MEDS that display only the indicator/aid code of those beneficiaries paying a premium. Only those beneficiaries with a premium aid code receive invoices for premium payment.

Until the State has this new process in place, the State will temporarily use the existing process under the Healthy Families Program, which is to exempt AI/ANs from cost sharing and premiums under Medi-Cal based on the individual being an AI/AN.

In addition to the exclusion of an AI/AN individual, non AI/AN individuals exempt from copays also receive an indicator/aid code that precludes them from receiving copays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory CALIFORNIA

c. Enforcement

i. __/ Prepayment is required for the following groups of applicants when they apply for Medicaid:

ii. __/ Prepayment is required for the following groups of beneficiaries as a condition for receiving Medicaid services for the premium period:

iii. X/ Eligibility is terminated for failure to pay premiums after a grace period of 90/120 days after the premium due date (at least 60 days) for the following groups of Medicaid beneficiaries:

•1-6 years of age, with family income above 160 percent of the FPL and up to and including 261 percent of the FPL will terminate after 90 days from age 1-6 years of age. •6-19 years of age, with family income above 160 percent of the FPL and up to and including 261 percent of the FPL will terminate after 90 days from age 6-19 years of age.

iv. **X**/ Payment will be waived by the state on a case-by case basis, if payment would create undue hardship for the individual.

D. Period of determining 5 percent aggregate family limit for premiums and cost sharing:

Specify the period for which the 5 percent maximum will be applied.

__/ Quarterly
X/ Monthly

E. Method for tracking beneficiaries' liability for premiums and cost sharing:

1. Describe the methodology used by the State to identify beneficiaries, who are subject to premiums or to cost sharing for specific items or services.

   RESPONSE: California will use aid codes to identify beneficiaries with family incomes above 160 percent FPL. These individuals will have premium payments and will require cost sharing tracking. Family incomes at or below 160 percent of the FPL do not require premiums tracking. The cost sharing tracking process is outlined in the response below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

2. Describe how the State identifies for providers, ideally through the use of automated systems, whether cost sharing for a specific item or service may be imposed on an individual beneficiary and whether the provider may require the beneficiary, as a condition for receiving the item or service, to pay the cost sharing charge.

RESPONSE
California notifies providers by Medi-Cal Provider bulletins, Provider manual updates and Provider training.

3. Describe the State's processes (that do not rely on beneficiaries) used for tracking beneficiaries' incurred premiums and cost sharing under section 1916 and 1916A of the Act if families are at risk of reaching their total aggregate limit for premiums and cost sharing, how the State informs beneficiaries and providers when a beneficiary's family has incurred premiums and cost sharing up to its 5 percent aggregate limit, and how the State assures that the family is no longer subject to further premiums and cost sharing for the remainder of the monthly or quarterly cap period.

RESPONSE
California does not anticipate or expect the families with children in the Optional Targeted Low Income Children's (OTLIC) Program to reach or exceed the five percent monthly aggregate limit imposed by federal regulations on the assessed premiums or cost sharing. However, to ensure the family does not exceed the monthly aggregate limit imposed, California intends to implement a process that uses the family income and any applicable copayments incurred by all members in the family* reported to the counties to determine the maximum five percent cap and assess that amount against the premiums (or applicable copayments) required of the family each month. This five percent cap displays on the monthly premium statement of the beneficiary subject to premiums to inform them of the maximum dollar amount incurred each month before the family is no longer subject to further premium or cost sharing provisions. Currently, California only charges premiums for children in families with family income above 150 percent FPL. There are no enforceable copayments for these children but if their family members are subject to cost sharing, those charges will be counted towards the aggregate family limit.

The state's premium payment processor receives monthly files from MEDS for premium payment billing. Only those beneficiaries with a premium aid code appear on those monthly files.

Through the provision of a letter or self-attestation, AI/AN parents who meet the cost sharing exemption, will not be subject to nominal cost sharing
For copayment reporting, the anticipation is to work within the same logic currently used to report a share-of-cost amount. This system notifies the provider when a beneficiary

meets their monthly share-of cost (SOC) so that the provider does not continue to bill the beneficiary. The current process displays a $0 amount when the beneficiary meets their SOC. The new process will follow similarly the same logic and display $0 copay when the beneficiary or family reaches their 5 Percent cap.

California will use the process described above to track the cost sharing for the OTLIC Program and other Medi-Cal populations come 2014 and notify the beneficiary or family when they reach their 5 Percent cap. The process of notifying the beneficiary outside of provider notification is currently being developed. The anticipated completion of notifying the beneficiary is July 2014.

*(*Starting in 2014, even nominal, unenforceable copays that the beneficiary or family members may be subject to are included in the maximum aggregate five percent of family income cap*)

4. Describe the process through which beneficiaries may request that the State reassess the family's aggregate limit for premiums and cost sharing when the family's income has changed or if a family member's Medicaid enrollment is being terminated due to nonpayment of a premium.

RESPONSE

To request a reassessment of the family's aggregate limit, beneficiaries need to contact their county eligibility worker (EW). The EW requests information pertinent to the change in order to conduct a redetermination based on a change in circumstance in accordance with current policy and then either finds the beneficiary eligible to a full scope, no share-of-cost, no premium Medi-Cal program or reassesses the family limit accordingly.

Beneficiaries terminated due to nonpayment of a premium may request a fair hearing to review and reassess the family's premiums when they object to the termination. The beneficiary may at any time there is a change in circumstance, contact their county EW for a reassessment of income.

F. Public Notice Requirements:

Explain how the State meets the following public notice requirements at 42 CFR 447.76.

1. The requirement at 42 CFR 447.76(a) and (b) for making available certain information about the State's premiums and cost sharing policies and procedures to the general public, applicant, beneficiaries, and providers:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

RESPONSE
California began notifying the public of its premium policy, including differences based on income, through an established venue of public forums, departmental web pages, program notices, legislation and regulations, and stakeholder meetings and webinars in late 2012. California continues to work with stakeholders and the public on outreach concerning this policy.

Applicants and beneficiaries receive information from county agencies in the following forms: the Medi-Cal brochure, application, and evidence of coverage documentation, enrollment materials, and program regulations at the time of eligibility determination and redetermination.

Through outreach and training, individuals such as certified application assistors, who help families with their application, will also be familiar with the program's requirements and be able to communicate them to families when discussing the program. Any changes to the premiums would be presented in public forums.

2. The requirement at 42 CFR 447.76(c) to provide the public with advance notice and the opportunity to comment prior to submitting a State plan amendment (SPA) to establish or substantially modify alternative premiums and/or cost sharing under section 1916A of the Act.

(Note: The State must submit documentation with the SPA to demonstrate that this requirement was met.)

RESPONSE
On October 31, 2012, the State distributed draft pages in the SPA 12-018 to various stakeholder groups and posted all documents publicly on the department's website at http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx with a request for feedback by 3p.m. on November 9, 2012. All interested parties were encouraged to send their questions and feedback in writing to the email inbox dhcshealthyfamiliestransition@dhcs.ca.gov. The State also conducted public webinars on September 13, 2012 and October 23, 2012 in which proposed amendments in SPA 12-018 were presented to stakeholders and interested parties in person and over the Internet.

On December 4, 2012, the State forwarded copies of emails to CMS that the State had sent to stakeholders requesting comments on the waiver amendment and draft SPA, and copies of webinar presentations.

In addition, the State distributed a Tribal Notice to the California IHS/UIHP on August 24, 2012. The tribal notice informed tribal organizations of the proposed amendments in SPA 12-018 and the potential impact on the tribal organizations and its beneficiaries. The provisions in SPA 12-018 were also presented at the quarterly webinar held for tribal organizations on August 30, 2012. Subsequent to this the State

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

distributed a follow-up Tribal Notice to the California HIS/UIHP on April 26, 2013 updating the change in SPA number to 13-005 and reemphasizing the Medicaid expansion OTLIC Program. In addition, the State presented this information at the Indian Health Conference held on March 6, 2013.

The following are the specific public notices provided concerning premiums from the weblink:http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx

HFP Transition Resources
http://www.dhcs.ca.gov/services/hf/Pages/HFPStakeHoldersMeetingsByMonth.aspx
Stakeholder Meetings
August Transition documents:
General Transition Notice
Stakeholder Presentation
What we Tell Families.

September Stakeholder Meeting:
HFP to Medi-Cal Transition Strategic Plan (PDF) page 9

February Stakeholder Meeting
Toolkit Links: Healthy Families Program Transition to Medi-Cal: Frequently Asked Questions
ACWDL 12-33, Page 12

General Information:
http://www.dhcs.ca.gov/services/hf/Pages/FAQEligibility.aspx

Reminder Notices and FAQs sent at each phase contain a letter and a booklet for frequently asked questions of which premiums are a part of the questions.

Additional information

Notices provided to the public state premiums apply for income above 150 percent to 250 percent FPL. The State provides a webpage where all interested stakeholders such as advocates, consumers, counties, legislative staff, providers, and state associations may receive relevant updates on department program initiatives or new projects. The website to find the sign up for emails is: http://www.dhcs.ca.gov/Pages/DHCSListServ.aspx. The email to sign up is: http://apps.dhcs.ca.gov/listsubscribe/default.aspx?list=DhcsStakeHolders

Distributed Notices and Letters:
http://www.dhcs.ca.gov/services/hf/Pages/HFPTransitionNoticesLetters.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

Ref.: ACWDL 12-30 pages 2 and 3, http://www.dhcs.ca.gov/services/Documents/12-30.pdf

Stakeholder comments to ACWDL 12-30
http://www.dhcs.ca.gov/services/hf/Pages/ACWDL12-30Comments.aspx

ACWDL 12-33, page 2,
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf

Comments to http://www.dhcs.ca.gov/services/hf/Pages/ACWDL12-33Comments.aspx

FAQs Eligibility #4, #8, http://www.dhcs.ca.gov/services/hf/Pages/FAQEligibility.aspx

FAQs Phase 4A, page 7
http://www.dhcs.ca.gov/services/Documents/HFP%20Phase%204A%20-%20FAQ.pdf