



**Center for Medicaid and CHIP Services**

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**SMD# 13-002  
ACA #25**

**RE: Affordable Care Act Section 4106  
(Preventive Services)**

**February 1, 2013**

Dear State Medicaid Director:

This letter provides guidance to states on section 4106 of the Affordable Care Act. Section 4106(b) establishes a one percentage point increase in the federal medical assistance percentage (FMAP) effective January 1, 2013, applied to expenditures for adult vaccines and clinical preventive services to states that cover, without cost-sharing, a full list of specified preventive services and adult vaccines. In that circumstance, the increase would apply to such expenditures whether the services are provided on a fee-for-service (FFS) or managed care basis, or under a benchmark or benchmark-equivalent benefit package (referred to as an alternative benefit plan).

The specified preventive services are those assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). The services remain optional with one exception: effective January 1, 2014, the law requires that alternative benefit plans cover preventive services described in section 2713 of the Public Health Service Act as part of essential health benefits. Section 2713 includes, among others, the same services as those authorized for increased match under section 4106 of the Affordable Care Act.

The federal Agency for Healthcare Research and Quality supports the USPSTF, an independent panel of experts in prevention that makes recommendations on clinical preventive services on a graded scale. The Centers for Disease Control and Prevention supports the ACIP, a group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. Both groups publish their recommendations. A list of the services that are eligible for the increased FMAP can be found on the following websites:

<http://www.uspreventiveservicestaskforce.org/uspstf/topicsprog.htm> <http://www.cdc.gov/vaccines/s/schedules/hcp/adult.html>

In order for states to claim the one percentage point FMAP increase for these services, states must cover in their standard Medicaid benefit package all the recommended preventive services and adult vaccines, and their administration, and must not impose cost-sharing on such services. States' utilization review and approval procedures should conform to USPSTF and ACIP

periodicity or indications where specified. States should ensure that they have appropriate codes or modifiers available for providers to utilize a crosswalk from those codes and modifiers to the USPSTF and ACIP recommendations, and a financial monitoring procedure to ensure proper claiming for federal match.

The one percentage point increase to the FMAP under section 4106 applies only to certain federal matching rates specified in section 1905(b) and section 1905(y) of the Social Security Act (the Act). Specifically, for eligible services, section 4106 of the Act only applies to the following FMAP rates, as long as the FMAP does not exceed 100 percent:

- Regular FMAP rates calculated in the first sentence of section 1905(b) of the Act.
- FMAP rates specified in the first sentence of section 1905(b) of the Act for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.
- The enhanced FMAP specified in section 1905(b) of the Act relating to services provided to certain breast or cervical cancer patients.
- The increased FMAP rates for Medical Assistance for newly eligible mandatory individuals specified at section 1905(y) of the Act. We note, that although the FMAP indicated in section 1905(y)(1)(A) of the Act for calendar quarters in 2014, 2015, and 2016 is 100 percent, as indicated above, this FMAP may not exceed 100 percent.

We are adding new lines to the CMS-64 report to capture state expenditures incurred in the provision of services authorized under section 4106. States should use these new line items to reflect expenditures eligible for the additional one percentage point. As with all services reimbursed under Medicaid, states are required to maintain documentation supporting expenditures claimed under these new line items. This documentation must contain the coding, crosswalk, and controls procedures discussed above and must be made available to the Centers for Medicare & Medicaid Services (CMS) upon request.

#### Overlap with Other Services

We recognize that provision of the preventive services described in section 4106 may occur at the same time as other services eligible for enhanced or increased FMAP rates not identified above. For example, family planning services may include USPSTF preventive services and ACIP approved adult vaccines, and their administration, furnished during a family planning visit. Family planning services can be reimbursed at a 90 percent rate. In these cases, states should claim on the family planning line of the CMS-64 form, which is reimbursed at the 90 percent rate. If a state ordinarily claims these preventive services and adult vaccines as a separate service from the family planning service, it should continue to do so.

Certain USPSTF grade A or B preventive services and vaccine administration codes eligible for the one percentage point FMAP increase under section 4106 may also qualify as primary care services eligible for a temporary increase in the payment rates matched at 100 percent federal financial participation (FFP) for calendar years (CY) 2013 and 2014 per section 1202 of the Affordable Care Act. Under section 1202, the Medicaid rate in CYs 2013 and 2014 for such primary care services by or under the direction of an eligible physician will be the lower of the provider's charges or the 2013 and 2014 Medicare rate respectively. FFP is available for 100

percent of the difference between the Medicaid rate as of July 1, 2009 and the increased rate. Under section 1202, the state's regular FMAP rate will be available for the portion of the rate related to the July 1, 2009 base payment. An additional one percentage point will be available on that base amount under section 4106 of the Affordable Care Act. The following example illustrates the interaction of these two Affordable Care Act provisions.

**Example.** A state's regular FMAP is 60 percent and under section 4106 of the Affordable Care Act, the FMAP would be increased to 61 percent for certain affected preventive services effective January 1, 2013. The portion of the state's rate related to the July 1, 2009 base payment for certain affected primary care preventive services is \$70. In 2013 the state increases the rate to \$80 in accordance with section 1202 of the Affordable Care Act. The \$10 difference between the \$70 July 1, 2009 Medicaid rate and the increased rate of \$80 is eligible under section 1202 of the Affordable Care Act for 100 percent FMAP. Prior to the application of the Affordable Care Act provisions, the total federal funding for the \$70 provider payment rate would have been **\$42** (60 percent FMAP of \$70). With the application of section 4106 and 1202 of the Affordable Care Act, the total federal funding available would be **\$52.70**, calculated as **\$42.70** (61% (60 percent FMAP plus one percentage point) of the \$70 regular provider rate) plus **\$10** (100 percent of the difference between \$80 (the increased provider rate) and \$70 (the July 1, 2009 rate)).

#### Claiming the Increased FMAP in Managed Care

In order to be eligible for the one percentage point increased FMAP, states must make these services available to those enrolled in a managed care delivery system as well as those in a FFS setting, and must ensure that beneficiaries have no cost-sharing liability for these services. States have the authority to claim an increased FMAP for preventive services whether provided in a FFS setting or in a managed care program that is reimbursed through capitation rates that meet the requirements for actuarial soundness in 42 CFR 438.6(c).

The portion of the capitated rate that is attributable to preventive services and upon which an increased match may be claimed, may be determined prospectively based upon historical FFS data or data from the managed care plans (if available). The portion of the capitation rate claimed at the increased FMAP must be attributable only to services meeting the definition for preventive services under this section. The data used to establish the portion of the capitation rate that can be claimed at the increased FMAP rate should be the most recent complete and validated historical data available, whether from FFS or the managed care plans. In order to claim the increased FMAP states may need to amend their managed care contracts to require delivery of these services in accordance with the statute.

#### State Plan Modifications

States seeking the one percentage point FMAP increase should amend their state plans to reflect that they cover and reimburse all USPSTF grade A and B preventive services and approved vaccines recommended by ACIP, and their administration, without cost-sharing. States should provide an assurance in the state plan indicating that they have documentation available to support the claiming of federal match for such services, as described earlier in this letter. States

should provide an additional assurance stating that they have a method to ensure that, as changes are made to USPSTF or ACIP recommendations, they will update their coverage and billing codes to comply with those revisions. Please refer to the previously mentioned websites for USPSTF and ACIP updates.

#### Additional Policy Development

Certain preventive services listed by the USPSTF when provided by non-licensed practitioners have traditionally not been covered by Medicaid due to regulatory requirements limiting practitioners of preventive services to either physicians or licensed professionals. Although section 1905(a)(13) of the Act contains broad language authorizing payment for preventive services recommended by a physician or other licensed practitioner, the implementing regulation at 42 CFR 440.130(c) currently limits preventive services to those provided by a physician or other licensed practitioner of the healing arts (within the scope of practice under state law). Consistent with 4106(a), CMS proposed revisions to this regulation in the Notice of Proposed Rulemaking which went on display in the Federal Register on January 14, 2013, giving states the ability to recognize unlicensed practitioners in the delivery of these services. Should this policy be finalized, states would be able to claim the one percentage point match for preventive services delivered by practitioners other than physicians or other licensed practitioners. Until that time, however, the increased match is available only for those services that are delivered in accordance with existing Medicaid regulations.

We are eager to work with states to facilitate the implementation of these preventive services that can improve the health of beneficiaries. As you continue to consider and implement measures aimed at strengthening prevention, we are available to provide technical assistance on prevention related topics if you email us at: [MedicaidCHIPPrevention@cms.hhs.gov](mailto:MedicaidCHIPPrevention@cms.hhs.gov). If you have any questions regarding this letter, please contact Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,

/s/

Cindy Mann  
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medicaid and Children's Health Operations

Matt Salo  
Executive Director  
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.  
Executive Director  
National Academy for State Health Policy

Ronald Smith  
Director of Legislative Affairs  
American Public Human Services Association

Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures

William Garner  
Legislative Director  
National Governors Association

Debra Miller  
Director for Health Policy  
Council of State Governments

Christopher Gould  
Director, Government Relations  
Association of State and Territorial Health Officials