

**Questions & Answers on ACA Section 4106  
Improving Access to Preventive Services for Eligible Adults in Medicaid**

**STATE PLAN AMENDMENT (SPA)**

**Q1. Can a state submit a SPA to implement section 4106 at any time?**

A1. Yes, a state may submit a SPA at any time. The one percentage point increase in federal medical assistance percentage (FMAP) per the requirements outlined in section 4106 of the Affordable Care Act does not have an end date.

**Q2a. The state is under the impression that they only need to update the 3.1-A coverage pages for preventive services to claim the 1% FMAP increase. Does the state need to update their reimbursement pages as well to provide the required assurances?**

**Q2b. Can you please advise if CMS will require public notice in addition to the SPA for the 1% FMAP increase to take effect?**

A2. In order to receive the one percentage point FMAP increase, the state is required to submit a SPA with updated coverage pages. When a SPA is submitted with updated coverage pages, we will perform a review of the corresponding payment page(s). A state does not need to submit a SPA with revised payment pages, and conduct public notice, unless it wishes either to begin coverage and payment for these services or to change the existing payment rates (in other words, if the state already pays for the preventive services in some contexts, a payment SPA may not be needed if the state does not want to change the existing payment rate or methodology).

**Q3. Under what portion of the state plan should the state add the Affordable Care Act section 4106 information?**

A3. The preventive services information should be placed in item (13)(c), preventive services, of the pre-print. The State Medicaid Director (SMD) letter #13-002 indicates the information that should be added to the 3.1-A (and at the state's option, the 3.1-B) coverage limitations pages. CMS is available to provide technical assistance before you submit the SPA, or we can discuss the needed information during the review of your SPA.

**Q4. Is there a SPA pre-print the states can use to comply with section 4106 of the Affordable Care Act or is CMS planning to issue one?**

A4. For states seeking the one percentage point FMAP increase, the state plan amendment requirements are indicated on pages 3 and 4 of SMD letter #13-002. CMS will not provide a state plan template on section 4106 of the Affordable Care Act. However, staff are available to provide technical assistance prior to your SPA submission.

**Q5. Does a state that has both a fee-for-service (FFS) and a managed care delivery system, get the 1% FMAP increase when just the FFS benefit is amended or would the state have to concurrently amend its managed care authority document (SPA, waiver or 1115 demonstration project) to get the 1% FMAP increase?**

A5. A state would have to submit a SPA to amend the preventive services benefit in the state plan. Once that SPA is approved, the state generally is eligible for the enhanced FMAP for such services. The state should review its managed care authority document (SPA, waiver or 1115 demonstration project) to ensure that it reflects the coverage and cost-sharing provisions (as appropriate) of the preventive services benefit. The state will have to amend its Managed Care Organization (MCO) contracts to reflect the scope of coverage and the absence of cost-sharing for the preventive services benefit. To claim that enhanced FMAP for managed care payments, CMS must review the methodology that the state intends to use to estimate the value of the preventive services benefit in its capitation rates.

#### **SERVICES ELIGIBLE FOR THE ONE PERCENTAGE POINT FMAP INCREASE**

**Q6. If a state elects to cover preventive services to be eligible for the one percentage point FMAP increase, must we cover all of the United States Preventive Services Task Force (USPSTF) A and B preventive services or can we cover just a few?**

A6. All USPSTF grade A and B preventive services, Advisory Committee on Immunization Practices (ACIP) recommended vaccines, and their administration, must be covered without cost-sharing in order to be eligible for the one percentage point FMAP increase.

**Q7. Are fluoride treatments (also known as fluoride varnishes) eligible for the one percentage point increase in FMAP under section 4106?**

A7. No, fluoride varnish is not eligible for the one percentage point FMAP increase. In the future, if the USPSTF adds fluoride varnish to the A or B recommended preventive services, states will be required to cover the fluoride varnish with no cost-sharing. Per SMD letter #13-002, states should provide an assurance in the state plan indicating they have a method to ensure that, as changes are made to the USPSTF and ACIP recommendations, they will update their coverage and billing codes to comply with those revisions. As long as this assurance is in the state plan, states are not required to submit a SPA each time the USPSTF or ACIP makes changes to their recommendations.

**Q8. While section 4106 of the Affordable Care Act authorizes a 1% FMAP increase for tobacco cessation services for pregnant women, the SMD letter does not address this proposed increase. Please clarify if this qualifies for the 1% FMAP increase.**

A8. The USPSTF recommendation for tobacco use counseling for pregnant women is grade A. Therefore, tobacco use counseling for pregnant women shall receive the one percentage point increase in FMAP. In addition, section 4106 of the Affordable Care Act states "items and services described in subsection (a)(4)(D)". Therefore, the one percentage point increase pertains to the *comprehensive* tobacco cessation services for pregnant women that are described in section 4107 of the Affordable Care Act.

**Q9. Section 4106 of the Affordable Care Act states that "any medical or remedial services [designed] for the "maximum reduction" of physical or mental disability and restoration of an individual to the best possible functional level" was also authorized to receive 1% FMAP; however, the SMD letter does**

**not address this provision. Please clarify if this is included, if yes, please provide information as to how this should be captured in claims data.**

A9. The statute amended section 1905(b) of the Social Security Act (Act) only to provide for the higher federal matching rate for services and vaccines described in subparagraphs (A) and (B) of section 1905(a)(13) of the Act . These subparagraphs are limited to “clinical preventive services assigned a grade of A or B by the USPSTF, adult vaccinations, and comprehensive tobacco cessation for pregnant women. This is a subset of the services described in section 1905(a)(13) of the Act.

**Q10a. For Medicaid eligible children, the state does not reimburse for the immunizations due to the Vaccines for Children (VFC) program. The state only reimburses for the vaccine administration code. Are the administrative codes for children’s immunizations eligible for the preventive services FMAP increase?**

**Q10b. Can the fee for administration of the adult vaccines receive the one percentage point increase in FMAP?**

A10. Section 1905(a)(13)(B) of the Act is limited to adult vaccines, therefore, the following applies:

- *Children age 18 and under:* Vaccines are provided through the Vaccines for Children (VCF program). Therefore, the one percentage point increase does not apply. For this age group, the vaccine administration fee is not eligible for the one percentage point FMAP increase.
- *Individuals age 19 and 20:* Vaccines are not available through the VCF program for this age group. This age group may receive the one percentage point increase in FMAP on both the vaccines and the vaccine administration fee.
- *Adults ages 21 and older:* Both the ACIP recommended vaccines and the vaccine administration fee are eligible for the one percentage point increase in FMAP.

**Q11. In some of the recommendations, a drug is mentioned, for example, “aspirin to prevent cardiovascular disease.” Does the 1% FMAP increase apply to the drug?**

A11. No, the one percentage point FMAP increase does not pertain to prescribed drugs (including over-the-counter drugs prescribed by a healthcare professional) that are claimed on the “Prescribed Drugs” line of the CMS-64 form. However, the one percentage point FMAP increase applies to injectable drugs that receive a USPSTF grade A or B recommendation and are provided in a clinical setting for the primary purpose of prevention. Cost-sharing should be waived for such services.

**Q12. Do we receive the 1% FMAP increase on only those services identified by the USPSTF A and B?**

A12. The one percentage point FMAP increase is available only for USPSTF Grade A and B services, comprehensive tobacco cessation services for pregnant women, ACIP recommended vaccines for adults, and their administration.

**Q13. In the law it is found under Adult preventive services. I noticed that the items listed in the USPSTF grade A and B services include screening for children. Does the 1% FMAP increase only apply to services provided to adults (beneficiaries ages 21 and older)?**

A13. The one percentage point FMAP increase applies to the USPSTF grade A and B recommended services for the populations referenced in the recommendations.

**Q14. Will the one percentage point FMAP increase apply to the expansion population after the period of 100% Federal match if the grade A and B services, etc. are covered without cost-sharing?**

A14. The newly eligible FMAP (described in section 1905(y)(1) of the Act) is 100 percent in calendar years 2014-2016, 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent in calendar years 2020 and beyond.

For states who opt to provide the services mentioned in section 4106 of the Affordable Care Act without cost sharing, for calendar years 2014-2016, the one percentage point increase for newly eligible individuals wouldn't apply, as the FMAP for that group is 100 percent.

Starting in 2017 and beyond, when the newly eligible FMAP goes to 95 percent and below, the one percentage point increase for the services mentioned in section 4106 of the Affordable Care Act would apply to the newly eligibles. Example: For 2017, newly eligibles would receive 95 percent FMAP. If the state opts to provide the services mentioned in section 4106 of the Affordable Care Act without cost sharing, per the guidelines in SMDL 13-002, the state would receive 96 percent FMAP on such services for the newly eligibles.

**Q15. Is it correct that any family planning service that also appear in services recognized under section 4106 are not eligible for the 1% FMAP increase since we receive a 90% match already?**

A15. Yes, that is correct. The one percentage point FMAP increase under section 4106 applies only to the FMAP set forth under section 1905(b) and section 1905(y) of the Act; it does not apply to FMAP rates under section 1903(a) of the Act. However, any family planning related service that also is recognized by section 4106 and matched at the state's regular FMAP is eligible to receive the one percentage point FMAP increase.

**Q16. Do we receive a 1% FMAP increase for services provided to beneficiaries who have other health insurance coverage besides Medicaid?**

A16. If the state is meeting the requirements outlined in SMD letter #13-002, the state may receive the one percentage point FMAP increase on the Medicaid liability after coordination of benefits occurs.

**Q17. Per state statute, my state currently covers breast cancer screenings at the USPSTF Grade C level. Breast cancer screenings are on the USPSTF list as a Grade B service with a different periodicity level. Will we still be eligible for the 1% FMAP increase if we cover the breast cancer screening at the USPSTF Grade C level, but cover all of the other USPSTF Grade A and B services, ACIP recommended vaccines, and their administration without cost-sharing?**

A17. All USPSTF grade A and B services, and ACIP recommended vaccines and their administration, must be covered without cost-sharing in order to be eligible for the one percentage point FMAP increase. The Department of Health and Human Services, in implementing the Affordable Care Act under the standard set out in revised section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendations on breast cancer screening of the USPSTF. Therefore, we are adopting a flexible approach for states to

receive a one percentage point FMAP increase for breast cancer screening. States can choose to use either the 2002 USPSTF grade B recommendation or the most current USPSTF recommendation (which is the grade B recommendation updated in 2009). The 2002 USPSTF recommendation is that women age 40 years and older should receive a screening mammography every one to two years. The 2009 USPSTF recommends biennial screening mammography for women aged 50 to 74 years of age.

**Q18. Are clinical preventive services that receive an I or C recommendation ineligible for Medicaid coverage? Are they ineligible for the increased FFP?**

A18. Clinical preventive services that receive an I or C recommendation are eligible for Medicaid coverage. States determine medical necessity criteria, and determine whether they will cover I or C recommended services. However, USPSTF grade I and C recommended services are not eligible for the one percentage point FMAP increase.

**Q19. Are clinical preventive services that receive a D recommendation ineligible for Medicaid coverage?**

A19. Clinical preventive services that receive a D recommendation are eligible for Medicaid coverage. States determine medical necessity criteria, and determine whether they will cover D recommended services. However, USPSTF grade D recommended services are not eligible for the one percentage point FMAP increase.

**Q20. When will the guidance be available for whether unlicensed practitioners will be able to furnish the section 4106 services?**

A20. “Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment Final Rule” (CMS-2334-F), published in the Federal Register on 7/15/2013, conformed the regulatory definition of preventive services at § 440.130(c) with the statute relating to the issue of who can be providers of preventive services. Per the final rule, effective 1/1/2014, preventive services may be recommended by a physician or other licensed practitioner. Therefore, unlicensed practitioners will be able to furnish preventive services (including the services mentioned in section 4106), based on the recommendation of a physician or other licensed practitioner, according to the provider qualifications established by each respective state, within broad federal parameters. In order for states to receive the one percentage point FMAP increase for unlicensed practitioners, it is likely that a State plan amendment updating section (13)(c) of the state plan will be necessary. Please refer to the preventive service CMCS Informational Bulletin issued on November 27, 2013 for additional information regarding adding unlicensed practitioners to the preventive services section of the state plan.

**BILLING, CODING, AND CLAIMING ON THE CMS-64 FORM**

**Q21. Can CMS recommend a list of CPT and HCPCS codes to be covered for the corresponding USPSTF grade A and B recommendations?**

A21. While section 4106 of the Affordable Care Act states that USPSTF grade A and B services, ACIP recommended vaccines and their administration must be covered to secure the one percentage point

FMAP increase, it is incumbent upon state Medicaid agencies to continue to work with, and communicate to, providers concerning state-specific systems and appropriate codes. The information provided by the American Medical Association in the below link (the CPT Code Pocket Guide: Preventive services with cost-sharing waived) can be used as a starting point in creating a cross-walk from the USPSTF and ACIP recommended codes, but it is not all-inclusive.

<https://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-preventive-services.page>

In addition, the October 2012 State Health Official (SHO) letter, gave the below web site address for HCPCS codes effective for service dates on or after January 1, 2012, and contacts within CMS for questions regarding HCPCS codes.

<http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html>

**Q22. Is there a modifier to assist providers, payers and states in identifying preventive services?**

A22. The American Medical Association created modifier 33 in response to the Affordable Care Act requirements pertaining to preventive services. When the primary purpose of the service is the delivery of an evidence-based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending *modifier 33, preventive service*, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.

**Q23. Does the 1% FMAP increase apply to preventive visits (New patient preventive visit 99381-99387 and Established patient preventive visit 99391-99397) codes? These codes are not listed on the USPSTF A and B recommendations.**

A23. Section 4106 of the Affordable Care Act pertains only to USPSTF grade A and B recommended services, ACIP approved vaccines, and their administration. Therefore, the one percentage point FMAP increase does not apply to preventive visits.

**Q24a. If our program expects that a particular screening be done as part of an Evaluation and Management (E&M) coded visit, how does that relate to CMS coverage expectations?**

**Q24b. Counseling and verbal screening are often incorporated into an E&M visit. Does CMS require that states have distinct coding and reimbursement rates for physician time spent:**

- measuring blood pressure
- counseling about alcohol misuse
- making a referral for BRCA screening
- discussing breast cancer chemoprevention
- counseling on breastfeeding
- prescribing oral fluoride
- screening for depression
- screening for intimate partner violence
- screening for obesity

- **counseling to prevent skin cancer**
- **counseling on tobacco cessation**

A24. We recognize that an E&M service may include a USPSTF grade A or B service (for example, blood pressure screening). To receive the one percentage point FMAP increase, states are required to cover in their standard Medicaid benefit package all USPSTF grade A and B preventive services, ACIP recommended vaccines, and their administration, without cost-sharing. It is up to the state to determine how the billing should occur. In the examples mentioned above, if you consider these USPSTF grade A or B recommended services to be an integral part of the office visit, and they will not be billed separately, the state may continue that billing practice. The state may claim the one percentage point FMAP increase on the office visit only if the primary purpose of the office visit is the delivery of a USPSTF grade A or B service, and not if it is simply a component part of a different billed service. The state should work with providers and payers to ensure that Current Procedural Terminology (CPT) coding and reimbursement practices for preventive medicine services are followed. We wish to confirm that a state must be able to document expenditures claimed on the CMS-64 and we believe the best way to accomplish this is through the billing process.

**Q25. If the preventive service is bundled with other services, and the bundled service includes more than one preventive service, may the state allocate the bundled payment among the included services and claim the enhanced match for each of the preventive services? Example, in an annual exam, the physician provides both obesity counseling and alcohol misuse counseling. Can the state submit a claim for both the obesity counseling and the alcohol counseling?**

A25. It is up to the state to set up its payment methodologies and procedures. To the extent that the state processes a claim for a USPSTF grade A or B preventive service consistent with those procedures, it can claim the enhanced match for that claim. If the state elects a payment methodology using bundled services, generally it cannot claim the enhanced match. But there may be some instances in which it might be appropriate to allocate costs for bundled claims among the included components. To the extent that a state is interested in doing so, it must develop a cost allocation plan, and submit that for CMS approval.

**Q26a. The list of USPSTF preventive services describes services as being available for persons based on their sex and age range. For example: Abdominal aortic aneurysm screening (men): The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked. Are states required to follow the USPSTF grade A and B recommendations on age, gender and smoking status in order to claim the one percentage point FMAP increase for a particular service?**

**Q26b. Since some recommendations have start and stop ages, are states required to perform age edits on each service for each individual?**

A26. States may only claim the one percentage point FMAP increase on services that adhere to the USPSTF grade A and B recommendations on age, gender, periodicity and other criteria as indicated in the summary of recommendations. For instances where the USPSTF grade A and B recommendations have expanded age, gender or periodicity levels due to clinical considerations, practitioners should document in the patient's medical record the necessity for exceeding the grade A and B recommendations, and states may claim the one percentage point FMAP increase. When billing for

these services, payers may want to use modifier 33 to identify services that meet the criteria for the USPSTF grade A and B recommendations. Pursuant to page 2 of SMD letter #13-002, states should have a financial monitoring procedure in place to ensure proper claiming for federal match.

**Q27a. What diagnosis codes must be billed in order to claim the 1% FMAP increase (the USPSTF A and B does provide a list of codes – should we limit our review to them)?**

**Q27b. Are we required to make sure these services are for preventive screening and not for disease diagnosis? For example, anemia testing in pregnant women can be part of routine prenatal care, and a provider may order it later in a pregnancy if the woman complains of fatigue.**

**Q27c. The same service may be screening or diagnostic. How does CMS want states to differentiate? For example, we will pay a lab claim for a lipid panel. Having to match with the ICD code (e.g. the presence or absence of hyperlipidemia) is burdensome, and ICD code may reflect either existing condition or purpose of ruling out that condition.**

**Q27d. The Medicaid billing codes associated with the eligible preventive services verify that a service was provided; they do not differentiate between services that are provided for preventive reasons and services that are provided for diagnosis maintenance. We would like CMS guidance on how this differentiation is to be identified.**

A27. As long as the state covers all USPSTF grade A and B services, ACIP recommended vaccines, and their administration, without cost-sharing, such services will be eligible for the one percentage point FMAP increase. State Medicaid agencies should work with, and communicate to, providers concerning state-specific systems and the appropriate codes to use.

**Q28. Are states required to follow only the summary of recommendations, or other information in the recommendation statement such as frequency? If the latter, reviewing potentially a ten-year claims history (e.g. for a colonoscopy) will be extremely burdensome.**

A28. Provided that the services are medically necessary, states are required to follow only the summary of recommendations for the services that have a rating of A or B from the USPSTF. It is up to the state to have a financial monitoring procedure to ensure proper claiming for federal match.

**Q29. For breast screenings, may the state claim the interpretation of the x-ray for the one percentage point FMAP increase, or can only the x-ray itself be claimed?**

A29. The state may claim the 1% FMAP increase on **both** the professional component (interpretation of the x-ray) and the technical component (the actual taking of the x-ray).

**Q30. According to the USPSTF methodology "The Task Force also aims to update topics every 5 years, in order to keep recommendations in the Task Force library current according to criteria established by the National Guideline Clearinghouse™". Does the requirement of covering and claiming increased FFP for USPSTF A and B recommendations apply only to recommendations that are new, updated, or reaffirmed within the past five years?**



A30. Yes, the one percentage point increase in FMAP applies to all USPSTF grade A and B recommendations, including new, updated, and reaffirmed within the past five years.

**Q31. Providers are permitted to charge a copay for a member's office visit. This visit may include a variety of services including preventive and non-preventive services. The SMD letter indicates the enhanced FMAP is available if cost-sharing is eliminated for preventive services. We believe this to mean that the doctor cannot collect a copay for any visit in which preventive services are provided, regardless of whether the majority of services provided during the visit are non-preventive services. We would like CMS verification.**

A31. If the USPSTF grade A or B service is an integral part of the office visit that includes other services, and will not be billed separately, the state may permit providers to charge a copay for the office visit, as the office visit is not eligible for the one percentage point FMAP increase. If the USPSTF grade A or B service is billed separately, or is the only service furnished during the office visit, the state may not permit the provider to charge a copay. The state should work with providers to establish the appropriate billing codes and claims processing guidelines for these situations.

**Q32. What information is being required for the CMS-64 reporting requirement to claim the increased FMAP for managed care expenditures?**

A32. 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. An approved state plan amendment is required for the lines to be enterable on the CMS-64 form. As with all other services claimed on the CMS-64, the amounts reported on and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. The CMS-64 report form has been modified to allow for reporting of a state's managed care expenditures separate from the state's reporting of FFS expenditures. The total expenditures associated with services referenced in section 4106 would be reported on the requisite lines for managed care (line 18A4, 18B1d or 18B2d) and for FFS (line 34A).

**Q33. What federal matching rate will apply for services for which a higher payment is made under section 1202 of the Affordable Care Act, if the services also qualify for a higher FMAP under the provisions of section 4106 of the Affordable Care Act?**

A33. States that elect to cover all USPSTF grade A and B services, ACIP recommended vaccines and vaccine administration, without cost-sharing and who receive a SPA approval for such services shall receive the one percentage point FMAP increase per section 4106. Some of these services may also qualify as primary care services eligible for an increase in the payment rates under section 1202 of the Affordable Care Act. For these services, the federal matching rate is 100 percent for the difference between the Medicaid rate as of July 1, 2009 and the payment made pursuant to section 1202 (the increase). The federal matching payment for the portion of the rate related to the July 1, 2009 base payment would be the regular FMAP rate, except that this rate would be increased by one percent if the provisions of section 4106 of the Affordable Care Act were followed.