Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

November 13, 2013

Pat Nolting, Interim Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, Indiana 46204

Attention: Michael Cook

This letter is being sent as a companion to our approval of Indiana State plan amendment (SPA) 13-004 that extends the five percent rate reduction for reimbursement of dental, therapy, vision, podiatry, laboratory, and radiology services through December 31, 2013. We have determined that the cap of $1000 per twelve month period for dental services (Addendum to Attachment 3.1-A, page 6, item 10) is a companion issue to this SPA.

Following our review, the following questions remain. The State has previously responded on October 21, 2013 that the dental cap is not currently in effect due to the result of a court ruling and agreed to address the following questions as a companion issue.

Attachment 3.1A; Addendum page 6, item 10 (Dental Services):

1. Is the 12 month limit imposed at the beginning of each year, or is it a rolling limit that begins when a beneficiary utilizes a service?

2. What was the impetus/reason for the $1000 limitation?
    a. If the reason was budgetary, please provide the assumptions used to support the savings, if not already provided.
    b. If the reason for the limitation was duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes have you tried or considered to address this matter?

3. Please describe what occurs to beneficiaries who are impacted by this limitation. Can additional services beyond the proposed limit be provided based on a determination of medical necessity? Is there an exception or prior authorization process for beneficiaries that require services beyond the limitation?

4. If the limit cannot be exceeded based on a determination of medical necessity:
    a. How do those affected by the limitation obtain the medical services they need beyond the stated limits?
    b. Are beneficiaries billed and expected to pay for any care that may not be covered? Or, instead does the provider or practitioner absorb the costs of the provided services?

5. How is the limitation tracked?

6. Are both providers and beneficiaries informed in advance so they know they have reached the limit? Please summarize the process.

7. What is the clinical purpose of this benefit and is that purpose achieved under this limit?

8. Please indicate support that the $1000 annual limit achieves the purpose of the benefit through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community that resulted in assurance that the scope of services, with the $1000 annual limit, has clinical merit to achieve its intended clinical purpose.

Combined Dental / Denture Limitations:

9. CMS requested further clarification, through the 08-009 companion letter, regarding a combined limit between the dental and denture benefits. It is our understanding that the State is proposing a combined limit of $1000 which would apply to both dentures and also to dental services described in item 10. A state may not place an aggregate hard cap limit on a combination of benefit categories. States must develop a separate limit for each benefit they wish to limit. This is because an aggregate cap means that a beneficiary who has a medical need requiring use of one of the covered benefits such as dental might not have access to a different benefit such as dentures if the limit was reached on the other benefit.

The State's response to this companion letter should provide the information to answer these questions as well as any corrections that need to be made to the State Plan pages.

The State has 90 days from the date of this letter, to address the issues described above. Within that period the State may submit SPAs to address the concerns or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance. If you have any questions concerning this SPA, please contact Elizabeth Lewis at elizabeth.lewis@cms.hhs.gov, or (312) 353-1756 for more information.

Sincerely,

Alan Freund, acting

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations