DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 11, 2015

Mari Cantwell, Chief Deputy Director
California Department of Health Care Services
Director's Office, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 13-044. SPA CA-13-044 was submitted to my office on December 13, 2013 to implement a methodology for the appropriate FMAP rates, including the increased FMAP rates, available under the provisions of the Affordable Care Act applicable for the medical assistance expenditures under the Medicaid program associated with enrollees in the new adult group adopted by the State and described in 42 CFR 435.119.

The effective date of this SPA is January 1, 2014. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Supplement 18 to Attachment 2.6-A, pages 1-10

If you have any questions, please contact Tom Schenck by phone at (415) 744-3589 or by email at Tom.Schenck@cms.hhs.gov.

Sincerely,

/s/

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Nate Emery, California Department of Health Care Services
Alice Mak, California Department of Health Care Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 13-044	2. STATE CA
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2014**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **1905(y) of the Social Security Act.**	7. FEDERAL BUDGET IMPACT: a. 2014 $0.00 b. 2015 $0.00 Relevant fiscal impact reflected in SPA, 13-0028
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Supplement 18 to Attachment 2.6-A, pages** 1-10 (TS)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: None

10. SUBJECT OF AMENDMENT:
Implementation of an increased federal medical assistance percentage (FMAP) matching rate offered to individuals who are eligible or enrolled in the Adult Group; income threshold methodology.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.

ORIGINAL SIGNED

14. TITLE:
Director

15. DATE SUBMITTED: DEC 13 2013

~~16.~~ RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 13, 2014	18. DATE APPROVED: MAR 1 1 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2014	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Hye Sun Lee	22. TITLE: Acting Associate Regional Administrator

23. REMARKS:
Pen and Ink change, box 8

FORM HCFA-179 (07-92)

State Plan Under Title XIX of the Social Security Act

State: California

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The state will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on April 15, 2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in the Table 1 Summary Chart. The numbers in the Table 1 Summary Chart will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.

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State: California

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	*Attachment A, Column C, Line 1* of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	No	No	No	No
Disabled Persons, non-institutionalized	*Attachment A, Column C, Line 2* of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	Yes	No	No	No
Disabled Persons, institutionalized	*Attachment A, Column C, Line 3* of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	Yes	No	No	No
Children Age 19 or 20	*Attachment A, Column C, Line 4* of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan	N/A	N/A	N/A	N/A
Childless Adults	*Attachment A, Column C, Line 5* of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan	N/A	N/A	N/A	N/A

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Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. _X_ California applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.
   ___ California does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B)

   Table 1 indicates the group or groups for which California applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   California:

   _X__ Applies existing state data from periods before January 1, 2014.

   ___ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ___ An enrollment cap adjustment is applied (complete items 2 through 4).
   _X_ An enrollment cap adjustment is not applied (skip items 2 through 4 and go to Section C).

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2. Attachment C describes any enrollment caps authorized in Section 1115 demonstrations as of December 1, 2009, that are applicable to populations that California covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable Section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. California applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ___ Yes. The combined enrollment cap adjustment is described in Attachment C

   ___ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. ___ California applies special circumstances adjustment(s).
   _X_ California does not apply a special circumstances adjustment.

2. ___ California applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
   _X_ California does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

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Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

_X_ Individuals previously eligible for Medicaid coverage through a Section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a Section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

___ [State] does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

California:

_X_ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 4)

___ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated ________________(insert date)

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

California:

_X_ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

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State: California

___ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated ____________ (insert date). The [STATE] will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

California attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

_X_ Attachment A – Conversion Plan Standards Referenced in Table 1

_X_ Attachment B – Resource Criteria Proxy Methodology

___ Attachment C – Enrollment Cap Methodology

___ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

_X_ Attachment E – Transition Methodologies

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State: California

ATTACHMENT A – Conversion Plan Standards Referenced in Table 1

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibility standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives** FPL %	100%	109%	yes	Part 1 of approved state MAGI conversion plan	SIPP
2	**Noninstitutionalized Disabled Persons** FPL %	100%	128%	n/a	new SIPP conversion	SIPP
3	**Institutionalized Disabled Persons** SSI FBR%	same as non-institutionalized disabled	same as non-institutionalized disabled	n/a	same as non-institutionalized disabled	same as non-institutionalized disabled
4	**Children Age 19-20**	n/a	n/a	n/a	n/a	n/a
5	**Childless Adults**	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable.

Note: The numbers in this summary chart will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.

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ATTACHMENT B – Resource Criteria Proxy Methodology

The resource proxy applied to the disabled non-institutionalized and disabled institutionalized sub-population groups is determined for those individuals in the 1902(a)(10)(A)(i)(VIII) coverage group, who are age 19 or older and not yet reached 65 years of age, not pregnant, and not enrolled in Medicare parts A or B, using state data recorded in the Medi-Cal Eligibility Data System (MEDS), and following the methodology described below:

1) Determine the number of disabled individuals in the universe of unduplicated adjudicated applications in calendar year 2013. The Department will query MEDS to obtain the total number of disabled applicant individuals (non-SSI/SSP), who are 19 years of age up to and through 64 years of age, who are not pregnant, and who are not enrolled in Medicare Parts A or B. Applications received by disabled individuals will be determined as follows:
   - MEDS BENDEX record. The Social Security Administration (SSA) information is queried automatically upon application information received in MEDS. The disability information received from SSA on BENDEX is stored on each applicant's MEDS record, and that information will be used to determine an individual's disability, or
   - A 2013 onset date and a disability aid code present on the individual's record in MEDS.
   - The outcome of this query is 146,660 applications received in 2013

2) Determine the number of adjudicated applications that were denied for excess resources in 2013. The Department will then count the number of those in (1) above that were denied for excess resources as follows:
   - Identify the number of applications identified in step (1) who's MEDS record indicates a denial code "G", application denied for the reason of excess resources.
   - The outcome of this query is 1,756 applications denied for excess resources in 2013

3) Determine the percentage of disabled individuals denied for excess resources in 2013. The percentage of individuals denied for reason of excess resources will be calculated by converting the following fraction to a percentage.

$$\frac{1,756}{146,660} = 0.01197 \text{ or } 1.197\%$$

The resulting percentage of 1.197% will be applied to claims submitted for those individuals in the new (VIII) group who are in the disabled non-institutionalized and disabled institutionalized sub-population groups.

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ATTACHMENT E – TRANSITION METHODOLOGIES

Under California's Bridge to Reform Demonstration (11-W-00193/9), DHCS has implemented the early expansion of the new adult populations, known as the Medicaid Coverage Expansion (MCE) population under the Low Income Health Program (LIHP). DHCS will use existing LIHP enrollee eligibility data to administratively move and enroll the MCE population into Medi-Cal effective January 1, 2014. The MCE component has an upper income limit set at 133 percent of the Federal Poverty Level (FPL). DHCS has determined that all MCE enrollees, whose income eligibility level is at or below 133 percent of the FPL using the Modified Adjusted Gross Income (MAGI) conversion methodology, would be eligible for Medi-Cal under the new adult coverage group. The LIHPs currently apply income eligibility determination rules and income deductions and disregards similar to those of the current Medi-Cal program. During the LIHP application and redetermination processes, the LIHPs would have already verified the enrollees' identity, citizenship/immigration status, California residency and met these non-financial requirements.

The MCE population is currently identified in the State's Medi-Cal Eligibility Data System (MEDS) under five specific LIHP aid codes, F5, F6, F7, F8, and 84. For transition purposes, DHCS will use MEDS reported December 2013 LIHP eligibility to assign the MCE population a new Medi-Cal transition aid code during the December 2013 MEDS renewal cycle whereby system data is refreshed to show month of eligibility for the coming month. Using this administrative process, LIHP enrollees will be automatically enrolled into Medi-Cal with an effective January 1, 2014 month of eligibility. DHCS will send the MCE enrollees that transition a 'Welcome to Medi-Cal' letter informing them of their eligibility in the Medi-Cal program. Additionally, DHCS will administratively terminate the enrollees' LIHP eligibility in MEDS effective midnight December 31, 2013.

In using this administrative process, new Medi-Cal eligibility information for each enrollee will be maintained in MEDS until their next scheduled redetermination, as established by the LIHPs or earlier, if the enrollee reports a change of circumstance that would affect their ongoing eligibility.

Redeterminations for transitioned MCE populations

After DHCS' administrative move to establish Medi-Cal eligibility for the transitioned MCE population, the local county social services department, which is the designated entity to conduct Medi-Cal eligibility determinations, will be responsible for ongoing case management and other ongoing eligibility related activities for these individuals effective January 1, 2014. The county social services department will complete the eligibility review for each transitioned MCE enrollee using the redetermination dates established by the LIHPs for said individual. To minimize the operational impact to the local Medi-Cal program, the transitioned MCE population will follow the same annual redetermination procedures as the current Medi-Cal population, using existing state statute and established program

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policies and procedures for such efforts. For the 2014 redetermination, the transitioned MCE population will be subject to the use of the MAGI provisions. Additionally, under authority of 1902(e)(14)(A) and 2107(e)(1)(E) of the Social Security Act (Act) as referenced in the Centers for Medicare and Medicaid Services letter dated December 23, 2013, California has received waiver approval to extend the dates for California's eligibility renewals scheduled for January 1, 2014 through March 31, 2014 for three months. Under such authority, DHCS will grant the county social service departments authority to also delay eligibility renewals for individuals transitioned to Medi-Cal from the MCE population. The eligibility renewal delay period and process for the transitioned MCE population will align with the policy for other MAGI Medi-Cal populations. During the renewal delay period, also known as the "grandfathering period" of January to March 2014, no adverse actions can be applied because of an MAGI eligibility determination for Medicaid populations who are transitioning from the "old" Medi-Cal eligibility rules to the new MAGI eligibility rules. This Medicaid protection however does not apply to the transitioned MCE population because they are a new eligibility group for Medicaid and there are no "old" eligibility rules that could be more advantageous. Therefore, county social service departments have been directed to take action upon reported changes submitted by transitioned individuals. However, as noted above, the renewal delay for the first Quarter of 2014 will be applied to the transitioned MCE population.