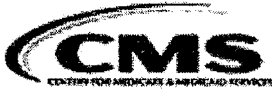

Medicaid Administration

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority — A1

42 CFR 431.10

Designation and Authority

State Name: California

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Department of Health Care Services (DHCS)

Type of Agency:

- ○ Title IV-A Agency
- ● Health
- ○ Human Resources
- ○ Other

Type of Agency:

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

Welfare and Institutions Code Sections (W&I) 10720 et seq., 10740, 14100.1 and California Senate Bill N. 162, Chapter 241, Statutes of 2006, Section 35 (regulatory Authority: 10725, 14105, 14124.5)

The single state agency supervises the administration of the state plan by local political subdivisions.

● Yes ○ No

The state statutory citation for the legal authority under which the agency supervises the administration of the plan on a statewide basis is:

W&I Code 10722 et seq., 10740, 14100

The state statutory citation under which the single state agency has legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is:

W&I Code 10725 et seq., 10740, 10743, 10745,10800 et seq. and 14100, 14100.1

Medicaid Administration

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

◉ Yes ○ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 12/06/13

The type of responsibility delegated is (check all that apply):

☐ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

California Department of Social Services (CDSS)

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agenoy, and the resources and/or services of such agency to be utilized in administration of the plan:

CDSS, another state agency within California's executive branch, receives fair hearing requests, conducts Medicaid fair hearings through their statewide network of administrative law judges and renders decisions for Medicaid fair hearings on behalf of DHCS. These fair hearings are for Medicaid eligibility and benefit decisions for applicants and beneficiaries, including Modified Adjusted Gross Income (MAGI) Medi-Cal determinations conducted by the Exchange. This does not include Medicaid eligibility decisions made by the Social Security Administration as part of the agreement with California allowed by Section 1634 of the Social Security Act. Fair hearings are not conducted at the local jurisdiction (county) before submission to CDSS. All fair hearings conducted by CDSS are de novo fair hearings. Provider hearings are conducted by the DHCS Office of Administrative Hearings and Appeals.

These services are provided to DHCS through a contract called an interagency agreement, which defines the duties of both agencies. Along with the interagency agreement there is a Delegation Order that gives the Administrative Law Judge authority to review and adopt decisions for hearings on most issues. These issues include: Medicaid eligibility decisions made by county staff under the direction of DHCS or those made by

Medicaid Administration

DHCS staff; most Medicaid scope of benefit issues except for those listed in the Delegation Order; Medicaid managed care issues except issues solely related to contractual requirements entered into by DHCS and the Medicaid managed care health plan; and Disability determination issues.

In addition to certain benefit issues the Delegation Order specifies that the following types of issues are always sent to DHCS as proposed decisions for review before the final decision is issued: Issues related to the 1915(b) Freedom of Choice, 1915(c) Home Community-Based Services waivers; and issues related to the Program for All-Inclusive Care for the Elderly; Issues related to Early and Periodic Screening Diagnosis and Treatment benefits; Supplemental Security Income/State Supplemental Program discontinuance cases where the beneficiary is receiving Medicaid only benefits pending an ex parte redetermination of eligibility; Any hearing decision based on beneficiary reimbursement that exceeds $5,000; Any decision that addresses a Medicaid issue that is also being prepared as a proposed decision for purposes of review by the director of another state department or agency, including, but not limited to, decisions concerning the Personal Care Services Program; Particular issues, as identified by either department, which are novel or unusual, sensitive or controversial in nature, or involve new program issues as identified by either department.

The initial hearing conducted by CDSS is de novo. In some cases, CDSS issues the decision as proposed if the issue is one that is specified in the Delegation Order. DHCS reviews the proposed decision, and CDSS finalizes the decision once it is reviewed by DHCS. CDSS issues all final decisions, but certain decisions (as specified by the delegation order) are always sent to DHCS as a proposed decisions for DHCS review prior to CDSS issuing the final decision. The CDSS final decision will contain any edits made by DHCS to a proposed decision.

After the final decision is issued, if the individual requests that DHCS review the decision within 30 days, DHCS reviews to ensure that the decision complies with State and federal law and all Medi-Cal policy directives. DHCS will also consider new information not available at the original hearing that might change the outcome of the hearing. The process of DHCS reviewing fair hearing decisions if requested by the claimant are not de novo. If DHCS grants the rehearing, CDSS schedules a new fair hearing with a different Administrative Law Judge. At this subsequent fair hearing, the information provided by DHCS will be considered along with the original information. The claimant has access to judicial remedy after the outcome of the first hearing whether or not the claimant files to have the case reviewed by DHCS.

DHCS provides consultation and technical assistance to CDSS staff on fair hearing issues related to federal and state law as well as Medicaid policy.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

DHCS:
1) Ensures that CDSS complies with all federal and State Medicaid laws, regulations and policies.
2) Retains oversight of the State Plan and will establish a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by CDSS.
3) Ensures that every applicant and beneficiary is informed, in writing, of the fair hearing process, how to contact CDSS, and how to obtain information about fair hearings from that agency.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☒ The Medicaid agency

Medicaid Administration

☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

☒ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

☒ Medicaid agency

☐ Title IV-A agency

☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

☐ Medicaid agency

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

◉ Yes ○ No

State Plan Administration
Organization and Administration A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The mission of DHCS is to preserve and improve the health status of all Californians. To fulfill its mission, the DHCS finances and administers a number of individual health care service delivery programs, including the Medicaid program (called the California Medical Assistance Program or Medi-Cal), which provides health care services to millions of low-income persons and families who meet defined eligibility requirements. The DHCS provides access to affordable, high quality health care, including medical, dental, mental health, substance use treatment services and long term care for eligible individuals and families.
The functions of DHCS are carried out by several portions of the department. The main functions are described below.
• Health Care Delivery Systems
There are two types of delivery systems in California. Medi-Cal managed care where health care plans are paid capitated rates to provide health services and fee-for-service, where services are paid as the health services are incurred (described under Policy and

Program Support below). The division that oversees the managed care delivery model is the Medi-Cal Managed Care Division. This division contracts managed care organizations to provide health care services for Medi-Cal beneficiaries.
Other divisions under this umbrella include:
The Long-Term Care Division (LTCD) which ensures the provision of long-term care services and supports to Medi-Cal eligible frail seniors and persons with disabilities to allow them to live in their own homes or community-based settings instead of in facilities. LTCD directly operates and/or administers five home and community based services waivers (HCBS). LTCD also provides monitoring and oversight for four HCBS waivers and the In-Home Supportive Services state plan benefit.
The Systems of Care Division creates effective and efficient comprehensive systems of care for vulnerable populations of children and adults with chronic conditions to better improve or maintain their health care status and reduce health care costs. This division is comprised of medical professionals who have oversight of several programs including Medical Therapy; High-Risk Infant Follow-up; and the Child Health and Disability Prevention Program among others.
The Low-Income Health Program Division administers the section 1115 "Bridge to Reform" Medicaid demonstration. The demonstration includes several programs that prepare the state for implementation of the Patient Protection and Affordable Care Act.

- Health Care Benefits and Eligibility

The Benefits Division is responsible for managing and ensuring the uniform promulgation of federal and state laws and regulations regarding Medi-Cal benefits and policies affecting medical providers and beneficiaries. Through an analysis process based on scientific, policy and practice evidence the Benefits Division adds, limits, modifies, or eliminates targeted services to increase patient safety, reduce risk and reduce the cost of care.
The Medi-Cal Eligibility Division, the division in DHCS that is responsible for overseeing policy for Medi-Cal eligibility determinations in California, is comprised of three branches. The Policy Development Branch oversees the majority of the Medi-Cal eligibility determination policy areas related to the administration of the Title XIX and Title XXI Medi-Cal and Medi-Cal Children's Health Insurance Program performed at the county level. The Policy Operations Branch oversees a limited number of policy areas for Medi-Cal eligibility determinations performed at the county level. Included in this workload are agreements with other state agencies within the California Health and Human Services Agency for disability determinations and for the Medi-Cal applicant and beneficiary fair hearing process.
Additionally the Policy Operations Branch houses five units involved in performing Medi-Cal eligibility determinations for BCCTP and Inmate eligibility. Three units determine eligibility for BCCTP and two units determine eligibility for inmates. The level of staff making these eligibility determinations is analyst level. These staff perform Medicaid eligibility determinations for Breast and Cervical Cancer Treatment Program and for State prison inmates in lieu of the county departments of social services. County departments of social services perform eligibility determinations for County inmates.
The Program Review Branch performs periodic reviews of county Medi-Cal eligibility determinations. This branch also oversees allocations to counties for performing Medi-Cal eligibility determinations.
The Pharmacy Benefits Division is responsible for DHCS' Medi-Cal fee-for-service drug program and for the management of the Medi-Cal managed care pharmacy program.
The Medi-Cal Dental Services Division is responsible for the provision of dental services to Medi-Cal beneficiaries. Services are provided under fee-for-service and managed care models.
The Office of Family Planning provides comprehensive family planning services to eligible low-income men and women. This includes information, assistance and services related to family planning.
The Primary and Rural Health Division improves the health status of diverse population groups living in medically underserved urban and rural areas.

- Health Care Financing

The Fee-For-Service Rates Development Division develops rates for Medi-Cal fee-for-service benefits. The Capitated Rates Development Division is responsible for developing capitated rates for Medi-Cal managed care plans. The Safety Net Financing Division administers supplemental payments in accordance with the "Bridge to Reform" Section 1115 Medicaid Waiver and the Medicaid State Plan. The division also oversees several hospital reimbursement and claiming processes programs that ensure eligible hospitals receive accurate payment for services. This division also oversees reimbursement to counties and local school districts for administrative activities, targeted case management and certain medically necessary school-based services.

- Mental Health and Substance Use Disorder Services

These divisions oversee policy for the provision of mental health and substance use through agreements with county mental health and substance use departments.
The Mental Health Services Division is responsible for the planning, delivery and monitoring of Medi-Cal mental health services with stakeholders and external partners.
The Substance Use Disorder Prevention, Treatment and Recovery Services Division directs statewide prevention and treatment programs that address the use and abuse of alcohol and other drugs. Its core functions include developing and implementing

prevention strategies; reviewing and approving county treatment program contracts; and granting applications submitted for state and federal funds for alcohol and drug abuse services.
The Substance Use Disorder Compliance Division focuses on compliance with State and Federal statute, regulations, and other governing requirements. The Division oversees the licensing and certification functions, monitoring, and complaints for Driving Under the Influence Programs, Drug Medi-Cal, Narcotic Treatment Programs, and outpatient and residential providers. The Division also ensures compliance with the statewide criminal justice treatment programs and counselor certification.
• Policy and Program Support
The entities under this heading provide administrative and system support as well as the functions highlighted below.
California Medicaid Management Information System (CA-MMIS) Division and the Information Technology Services Division are responsible for all activities associated with usage of California's information technology system, which processes and pays Medi-Cal fee-for-service health care claims. The divisions are also responsible for the overall administration, management, oversight, and monitoring of the fiscal intermediary contract and all services provided under the contract including the operation of a telephone service center, provider services and system operations.
Among its other duties the Information Technology Services Division supports the Medi-Cal eligibility subsystem. This is the system of record for use by the counties in determining and recording Medi-Cal eligibility. The system makes this information available to the Medi-Cal claims and capitated payment systems.
The Audits and Investigations Division performs financial and medical audits, post-service payment utilization review of providers; investigates provider and beneficiary fraud; and performs internal audit functions.
The Office of Administrative Hearings and Appeals processes provider hearing and appeal requests.
The Provider Enrollment Division is responsible for the reviewing and taking appropriate action on fee-for-service provider applications seeking to participate in the Medi-Cal program. This includes conducting re-enrollment functions and updating the provider database used in the Medi-Cal claims payment process.
The Third Party Liability and Recovery Division ensures that the Medi-Cal program complies with state and federal laws and regulations requiring that Medi-Cal be the payer of last resort. This is accomplished by recovering Medi-Cal expenses from liable third parties; avoiding Medi-Cal cost by identifying or purchasing alternative health care coverage; recovering health care costs from the estates or settlements of certain Medi-Cal beneficiaries; and collecting provider and beneficiary overpayments.
The Utilization Management Division provides cost-effective utilization controls by reviewing and adjudicating Treatment Authorization Requests for certain medical procedures, services and drugs for fee-for-service Medi-Cal beneficiaries prior to payment for services.

Upload an organizational chart of the Medicaid agency.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The DHCS is part of the California Health and Human Services Agency (CHHS), which oversees all state health, human service and public assistance departments/agencies in California. CDSS is another agency under the direction of the California HHSA.

DHCS has three distinct types of relationships with CDSS. First, CDSS is the state agency determining eligibility for the IV-A and IV-E programs. CDSS supervises counties in making these combined cash and Medi-Cal determinations with policy guidance from DHCS. The other role is as contractor. CDSS performs Medi-Cal state fair hearings as described above. CDSS also contracts with DHCS to provide disability determination services (determining if the applicant or beneficiary is disabled according to Social Security rules). This also includes determining if the recipient of a deceased Medi-Cal beneficiary's estate is disabled. Lastly, CDSS supervises the provision of Medi-Cal Personal Care Services with policy guidance from DHCS.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

Medicaid Administration

(•) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

( ) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Under the administrative guidance of DHCS and the supervision of the California Department of Social Services, the county departments of social services make Title XIX eligibility determinations for the following groups:
1. Title IV-A cash assistance-Temporary Assistance for Needy Families (called California Work Opportunity and Responsibility for Kids in California)
2. Title IV-E and non Title IV-E Foster Care, Adoption Assistance and the Kinship Guardian Assistance Program cash assistance.

Remove

Type of entity that determines eligibility:

( ) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

(•) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

( ) An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

( ) Yes (•) No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

(•) Counties

Medicaid Administration

◯ Parishes

◯ Other

Are all of the local subdivisions indicated above used to administer the state plan?

◉ Yes ◯ No

Indicate the number used to administer the state plan: 58

Description of the staff and functions of the local subdivisions:

Under the administrative guidance of DHCS, staff employed by the 58 County departments of social services, will access the business rules contained in the eligibility system for the Exchange agency, known as Covered California, to complete Medicaid determinations on the the basis of using MAGI. Once the eligibility determination has been completed by the Exchange eligibility system the results are returned to the county department of social services. The county department of social services is responsible for distributing notices, maintaining the case and renewing eligibility at least annually. These activities are accomplished by accessing the rules in the Exchange eligibility system whenever eligibility information in the case changes. The county department of social services represents DHCS at fair hearings for MAGI Medicaid eligibility issues.

Under the administrative guidance and supervision of DHCS county departments of social services staff perform eligibility determinations for most non-MAGI Medicaid programs. County departments of social services staff adjudicate non-MAGI Medicaid applications, maintain cases, renew eligibility at least annually and represent DHCS at fair hearings for Medicaid eligibility issues. County departments of social services do not conduct fair hearings but may, as part of their duties, engage in informal resolution processes to resolve fair hearing issues as expeditiously as possible.

County departments of social services do not perform eligibility determinations for the Supplemental Security Income/ State Supplementary Payment, Breast and Cervical Cancer Treatment or State prison inmate programs.

County departments of social services maintain personnel standards on a merit basis. As noted above, DHCS staff execute Medicaid eligibility determinations for certain programs.

State Plan Administration Assurances — A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Medicaid Administration

Assurances for states that have delegated authority to conduct fair hearings:

■ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

■ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☑ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.