

State of California—Health and Human Services Agency
Department of Health Services



California
Department of
Health Services

DIANA M. BONTA, R.N., Dr. P.H.
Director



GRAY DAVIS
Governor

August 27, 2003

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 281

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

ARTICLE 2 - ADMINISTRATION

Enclosed are updated pages of the procedures for the Medi-Cal Eligibility Quality Control (MEQC) Review Process. The procedures have been revised to reflect the current MEQC Review Process in California as authorized under the Geographic Sampling Pilot (GSP).

Article 2A "Medi-Cal Eligibility Quality Control (MEQC) Process Description" describes the quality control process under the GSP. This article contains two charts. The first chart identifies a county as large or small dependent on Medi-Cal population for inclusion in the monthly sample versus periodic reviews. The second chart identifies the aid codes to be included in the monthly sample as of April 2002.

Article 2B "Medi-Cal Eligibility Quality Control (MEQC) Corrective Action" describes the case review findings utilized by the MEQC Analyst and corrective action at the end of the review period. Also included in this procedure are the guidelines for the county welfare department Appeal process.

Article 2C "Medi-Cal Eligibility Quality Control (MEQC) Program Review Section (PRS) Field Offices" identifies the organizational structure of PRS and the three Regional PRS Managers.

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If you have any questions, please contact Ms. Mary Brown of my staff at (916) 552-9442.

Sincerely,

Original signed by

**Beth Fife, Chief
Medi-Cal Eligibility Branch**

Enclosures

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2A - MEDI-CAL ELIGIBILITY QUALITY CONTROL (MEQC) PROCESS DESCRIPTION

The Program Review Section, Medi-Cal Eligibility Branch has the responsibility for MEQC. The primary purpose of MEQC is to ensure that persons who are entitled to Medical Assistance Only (MAO) are given eligibility by identifying sample cases that were incorrectly denied or discontinued and identifying the reasons for the errors.

MEQC activities are federally mandated by the Center for Medicare and Medicaid Services (CMS) and designed under federal rules and authorization. Reviews are completed for the federally eligible part of the Medi-Cal program; therefore, state-only funded cases are excluded from review.

1. Overview

MEQC audits the county eligibility determination process based on a Geographic Sampling Pilot Project (GSP) initiated July 1, 1999. Prior to the GSP, MEQC reviewed a random sample of MAO cases for all 58 counties. The number of MEQC case reviews selected for each county was proportionate to its share of the statewide MAO beneficiary population. Under the GSP, only the 25 counties with the largest MAO population are included for the regular random sample. The remaining 33 counties are included in the Periodic Case Review (PCR) process. Under the PCR, counties are scheduled to have 10-50 cases reviewed on a periodic basis. A chart of California counties' MAO populations as of June 2002 is included in this procedure. The 25 large and 33 small counties are identified with the corresponding MAO population. The 25th county has changed as of April 2003 from Santa Cruz to Madera based on the MAO population.

During the life of the GSP, the State's error rate as identified by the Federal Government is frozen at 0.635 percent. This percent is the computed dollar error rate for fiscal year 1997, the most recently completed MEQC period prior to the inception of the GSP. The terms of the GSP preclude MEQC fiscal repercussions or sanctions for the duration of the pilot project. An annual report summarizing all MEQC activities is submitted to CMS on an annual basis to comply with the terms of the GSP.

In addition to the MAO monthly sample and the PCR, a Negative Action Case Review (NCR) is completed on a select number of counties each year. The NCR is an audit of persons denied or discontinued from the Medical Assistance Only (MAO) programs. The negative action is compared to the information in the case record for appropriateness and timeliness.

Other reviews have been developed based on identified needs. These reviews are categorized as Focused Reviews (FR). The FR is a specialized review of an issue specific to a county or specific to a program. See Article 2C for a list of current FCRs.

2. Review Process

The Medi-Cal eligibility review process for the MEQC sample differs from all other reviews. All cases in the MEQC sample are given a full investigation. This includes a review of the physical case record, the county's automated eligibility system as appropriate, and a field investigation if indicated. The field investigation may consist of a contact with the beneficiary

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or the beneficiary's representative through a home visit, phone call, or by mail. In addition, contacts with other sources may be made to verify information and research public records. A match to the Income Eligibility Verification Applicant System will be included for each case. All other review types are limited to the case record and the county's automated eligibility systems.

3. Sample Size

a. MEQC Sample

The MEQC sample for the 2003-2004 GSP will be conducted in the 25 large counties and is projected to be 2,520 cases. (14 cases monthly X 12 months X 15 staff persons, assuming fully trained experienced staff). The number of cases for each of the 25 counties is proportionate to the MAO population within the county. The sample is randomly selected from the recipient eligibility history file.

b. PCR Sample

The PCR sample for the 2003-2004 GSP, will be conducted in some but not all of the 33 small counties. The number of cases to be reviewed in each county will be proportionate to the MAO population within the county. The larger of the small counties will have no more than 50 cases reviewed. The smaller of the small counties will have no fewer than 10 cases reviewed.

c. NCR Sample

All counties, regardless of size, will be included in the NCR process. The number of cases to be reviewed in each county will be proportionate to the MAO population within the county. The largest county, Los Angeles, would have no more than 240 cases selected for review. The smallest county, Alpine, would have no more than 10 cases selected for review.

d. FR Sample

The size of an FR varies based on the focus of the review. In most cases the minimum number of cases is 50. As with the PCR and NCR, some reviews are based on the MAO population within the county.

4. Eligibility Review

The MEQC, PCR and FR reviews determine whether the sample cases were actually eligible for Medi-Cal benefits, the program to which they are entitled and the accuracy of the share of cost. The reviews normally occur the second month after the month of eligibility.

The NCR review determines whether the county took an appropriate action to deny or discontinue Medi-Cal benefits. The review usually occurs the third month after denial or discontinuance of eligibility.

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5. Appeal Process

When a case included in the MEQC sample is determined to have a discrepant case finding, a letter will be issued to the county. The letter identifies the discrepancy and the type of case finding. The county is allowed to appeal case findings of eligibility and liability errors. There is no appeal process for indeterminate, procedure, or pertinent case findings.

Cases included in the PCR, NCR, and FR process are not subject to the appeal process. Counties will be provided an opportunity to respond to discrepant case findings based on the review format and negotiated time frames. Individual case letters are not issued. Instead, the report for each of the processes will include a listing of cases and the findings for review. See Article 2B for more detail.

6. Corrective Action

Medi-Cal only eligibility error findings are transmitted to the counties on a flow basis through individual case letters for the MEQC sample. The counties are expected to correct individual cases involved. See Article 2B for more detail.

The findings from all MEQC reviews are used to identify focused reviews specific to a county or in general. Counties are encouraged to use the findings to identify patterns that indicate the need for corrective action within the county, including refresher training or revised county procedures.

7. County Consolidated Summary Report

A Consolidated Summary Report is completed for each of the 25 large counties designated by the GSP for each six-month period within the GSP. The reports for the April through September period are issued in January of each year. The reports for the October through March period are issued in July of each year. See Article 2B for more detail.



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Medi-Cal Eligibility Quality Control Counties

25 Largest Counties
(94 % CA MAO Population)

Los Angeles	1,171,454
Orange	186,117
San Diego	153,087
San Bernardino	139,217
Riverside	119,207
Fresno	110,075
Santa Clara	90,910
Kern	85,866
Sacramento	79,332
Alameda	67,429
Tulare	61,562
Ventura	56,588
San Joaquin	56,375
Stanislaus	53,807
Monterey	43,184
San Francisco	42,572
Contra Costa	41,852
Santa Barbara	34,292
Merced	32,366
San Mateo	30,148
Sonoma	22,895
Solano	22,630
Butte	22,608
Imperial	20,852
Madera	<u>17,845</u>
	2,762,270

Periodic Case Review Counties

33 Smallest Counties
(6 % CA MAO population)

Santa Cruz	17,171
Shasta	15,763
Kings	15,065
San Luis Obispo	14,499
Yolo	12,094
Humboldt	11,143
Mendocino	9,526
Sutter	9,392
Placer	8,026
Napa	7,290
Marin	7,113
El Dorado	6,734
Yuba	6,628
Tehama	6,267
Lake	5,419
Siskiyou	4,399
Nevada	4,374
San Benito	3,521
Glenn	3,312
Tuolumne	3,204
Colusa	3,131
Del Norte	2,869
Calaveras	2,423
Lassen	2,065
Inyo	1,746
Amador	1,710
Plumas	1,432
Mariposa	1,207
Modoc	1,054
Trinity	990
Mono	707
Sierra	218
Alpine	<u>114</u>
	190,606

Data from June 2002 Medi-Cal Beneficiary Count Report, Medically Indigent and Medically Needy



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2 B - - MEDI-CAL ELIGIBILITY QUALITY CONTROL (MEQC) CORRECTIVE ACTION REVIEW (CAR) PROCESS

Under the Geographic Sampling Pilot (GSP), cases included in the Medical Assistance Only (MAO) sample are subject to all components of the MEQC CAR process. Cases included in all other reviews will follow the definition of case discrepancy findings but have separate corrective action components based on the type of review.

1. Case Finding

The MEQC Analyst will determine a case finding for all cases reviewed. The case finding will be used to determine the entries into the MEQC Database on the Q5 System and used for the Consolidated Summary Report (See No. 6 below). In some case situations, more than one case finding may be identified. When this occurs, the following order of case findings will be used:

a. Indeterminate

The Section 1931(b) program is currently excluded from the MAO monthly MEQC sample, and is monitored through the Focused Case Review (FR) process. Because of the complexity of the Medi-Cal programs, cases with Section 1931(b) eligibility might be included in the MAO sample. Beginning with the October 2001 sample month, the MEQC Analyst will consider the implications of the Section 1931(b) program on other persons in the Family Budget Unit (FBU). When a discrepancy is noted, an Indeterminate finding will be documented for the county's consideration but will not be counted as a hard error citation towards the county's error rate.

b. Eligibility/Liability Error

An eligibility/liability error exists when at least one member of the MFBU receives Medi-Cal benefits to which he or she is not entitled.

An eligibility error exists under the following situations when a person receives Medi-Cal and was not eligible for any scope of services.

- An eligibility error with ineligible services error exists when a beneficiary receives full scope services and is only eligible for restricted services. This would include a pregnant woman who was eligible for pregnancy related services under the Asset Waiver Program who was issued full scope benefits.

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- If any case member has excess resources for all scope of services, there is an eligibility error. However, if the cost of medical services received in the review month exceeds the amount of excess resources, the final case error finding will be understated liability. The error amount will be the amount of excess resources.
- As of December 11, 2000, an eligibility error will be cited when the County Welfare Department (CWD) cannot locate the case record and there is insufficient information in the electronic file to justify the benefits that were issued.

A liability error exists when there is a difference of \$400 or more in the amount of the share of cost (SOC) calculated by the county as compared to the SOC calculated by State Quality Control (QC). This change became effective with the April 2002 sample month.

- If the State SOC computation is less than the SOC computed by the county, the liability is an overstated SOC error.
- If the State SOC computation is more than the SOC computed by the county, the liability is an understated SOC error.

c. Procedural Error

A procedural error exists when there is a difference between the case record information and an error in how the agency treated the information that does not result in an eligibility/liability error. Procedural errors include those case situations in which:

- The amount of the SOC calculated by the county as compared to the SOC calculated by State QC is less than \$400. This change became effective with the April 2002 sample month.
- The change, which caused the error, occurred in the administrative period.
- The difference would not cause a difference in eligibility or liability.

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d. Pertinent Information

A pertinent information situation exists when there are changes or unreported information that has no impact on the review month but may be of importance for future months of eligibility.

e. Dropped Cases

A case drop situation exists when one of the following situations occur:

- All beneficiaries are cash assistance recipients or in a 100% federally funded program. For example, cases for persons receiving medical assistance under the Refugee Resettlement Program are not included in the MAO sample. These cases would not normally be selected through the automated sampling pilot but if included will be dropped without any MEQC review.
- The beneficiary moves out of the state after the review month and there is insufficient information available to complete the case. An eligibility error is cited when a beneficiary moves out of the state prior to or during the administrative period.
- The beneficiary cannot be located to complete the review or refuses to cooperate with the review process and there is insufficient information in the case record to complete the review.

2. Administrative Period

All MEQC reviews require the examination of case circumstances and eligibility as of the review month. The MEQC Analyst will evaluate eligibility based on the administrative period. This period covers two months – the review month and the month prior to the review month. If an error occurs due to a change during the administrative period, an eligibility/liability error will not be cited unless the CWD completed an incorrect change.

There are situations in which the administrative period is not applied.

- The eligibility status of the case was incorrect as of the review month and would remain incorrect regardless of the change in circumstances.
- The agency incorrectly adjusted the eligibility/liability status of the case based on a change reported during the administrative period.

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- Terminated Continuing Medi-Cal Coverage (CMC) or Transitional Medical Care (TMC) cases are erroneously extended past the time limit for the program. For CMC cases this is a four-month time limit. For TMC, a six-month time limit applies.
- The case contains a Continuous Eligibility (CE) infant or pregnant woman and the provisions of CE eligibility apply. The income for the review month may be the income used to determine the initial month of CE eligibility for the pregnant woman that is carried through to the end of CE for the infant.
- The case contains a Continuing Eligibility Children (CEC) child and the provisions of CEC eligibility apply. The income for the review month may be the income used to establish a new period of CEC eligibility.

The income to be used will be determined by the type of case under review and based on the income rules for that specific program. In computing the SOC, the MEQC Analyst will use the following procedures:

- a. With the inception of April 2002 case reviews, calculate the SOC using the averaged income received in the review month. If there is a difference between the SOC calculated by the CWD and the SOC calculated by the State of less than \$400, no further calculations are necessary. If the SOC is \$400 or more go to step b.
- b. With the inception of April 2002 case reviews, if the SOC based on the averaged income received in the review month differs by \$400 or more, calculate the SOC using the income received in the administrative month prior to the review month. If the difference in the SOC is less than \$400, no further calculations are necessary. If the SOC is \$400 or more go to step c.
- c. With the inception of April 2002 case reviews, if the difference in the SOC is greater than \$400 in the review month and the prior month, calculate the SOC using the income received two months prior to the review month. If the difference in the SOC is less than \$400, no further calculations are necessary. If the SOC is \$400 or more go to step d.
- d. With the inception of April 2002 case reviews, if the difference in the SOC from step c is greater than \$400, an error must be cited.

The case facts must be evaluated to determine error responsibility in those cases with a \$400 or more SOC difference. If it is determined that the error is beneficiary caused, the converted review month income will be used to compute the SOC. When the error is deemed to be agency caused, use the converted income received two months prior to the review month. If the

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CWD completes a budget change during the administrative period it must include budget information available as of the date of the budget change. If information affecting the SOC is disregarded and the result is an error of \$400 or more, an agency error will be cited.

3. Corrective Action

Medi-Cal only (MAO?) eligibility error findings are transmitted to the counties on a flow basis through individual case letters for the MEQC sample. The counties are expected to review and take corrective action on the individual cases involved. Only those case letters identifying eligibility/share of cost errors will include a request for the CWD to respond within 10 calendar days. This response process is covered under the Appeal Process (see #4 below). In all other situations except for dropped cases, a follow-up Corrective Action Review (CAR) is conducted six months following the close of the review period to determine if corrective action has occurred. The CWD will be contacted to request information for cases, which cannot be reviewed through the State MEDS system. (See #5 below for the Dropped Case process.)

The findings from all MEQC reviews are used to identify focused reviews specific to a county or in general. Counties are encouraged to use the findings to identify patterns that indicate the need for corrective action within the county, including refresher training or revised county procedures.

4 Appeal Process

When a case included in the MEQC sample is determined to have a discrepant case finding, a letter is authorized for issuance by the MEQC Regional Manager with responsibility for the county. The letter identifies the discrepancy and the type of case finding. This action initiates the Appeal process.

a. First Level Appeal

The CWD has 10 working days from the date of the letter to disagree with a QC error. If the County disagrees with the cited error(s), a written first level appeal is returned to the PRS Regional Manager with responsibility for that county. The appeal response is evaluated with any additional facts provided by the county. One of four actions will then result:

- The error will be rescinded and the case considered correct with no additional issues.
- The error will be rescinded and a new letter issued because of procedural

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or pertinent information issues ending the appeal process.

- The error will be modified and a new error letter issued continuing the appeal process into a second appeal level. The county will not be given an additional first level appeal. This includes those situations in which the original error occurred because the county was unable to provide the case record and there was insufficient information in any automated system to determine the accuracy of the scope of services and/or share of cost.
- The original error will be sustained continuing the appeal process into a second appeal level.

b. Second Level Appeal

If the county continues to disagree with the case finding, a second level appeal may be made to the Section Chief, Program Review Section. The second level appeal must be made within 30 calendar days of dismissal of the first appeal.

The County will be instructed to send second level appeals to:

Tom Welch, Chief
Department of Health Services
Program Review Section
MS 4610
P.O. Box 942732
Sacramento, CA 94234-7320
FAX: (916) 552-9478

The appeal response is evaluated with any additional facts provided by the county. One of four actions will then result:

- The error will be rescinded and the case considered correct with no additional issues.
- The error will be rescinded and a new letter issued because of procedural or pertinent information issues ending the appeal process.
- The original error will be sustained ending the appeal process.

Cases included in the Periodic Case Review (PCR), Negative Case Action Review (NCR) and Focused Review (FR) process are not subject to the appeal process.

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based on the review format and negotiated time frames. Individual case letters are not issued. Instead, the report for each of the processes will include a listing of cases and the findings for review.

5. Dropped Cases

A case will be dropped when the MEQC Analyst is unable to complete a review because the beneficiary cannot be located to complete the review or refuses to cooperate with the review process. In addition, a case will be dropped when there is insufficient information in the case record to complete an accurate eligibility determination. This analysis will be based on what information is available from the case record, from contact with the beneficiary and third party sources. A letter will be sent to the CWD advising of the noncooperation and dropped case status. The County will be requested to attempt to contact the beneficiary and obtain cooperation with the MEQC review process and evaluate for discontinuance of Medi-Cal benefits if the beneficiary is noncompliant.

If the beneficiary cooperates with the MEQC review process within 45 days of the case drop notification, the MEQC Analyst will advise the County that the beneficiary has cooperated and the change in case status. If the beneficiary cooperates with the County and provides the information and/or verifications missing from the case review, the County should forward to the MEQC Analyst in order for the review to be completed. Cooperation with the Medi-Cal Quality Control process is mandated by federal regulation under 42 CFR 431.800 and 431.801. If the beneficiary does not cooperate, the case will be excluded when calculating the County's quality control accuracy rate.

6. County Consolidated Summary Report

A Consolidated Summary Report is completed for each of the 25 large counties designated by the GSP for each six-month period within the GSP. The county receives an individual letter specific to the county and in comparison to the other 24 large counties included in the MEQC sample activity. The reports for the April through September period are issued in January of each year. The reports for the October through March period are issued in July of each year.



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2 C - - MEDI-CAL ELIGIBILITY QUALITY CONTROL (MEQC) PROGRAM REVIEW SECTION (PRS) OFFICES

The Program Review Section (PRS) is contained within the Medi-Cal Eligibility Branch (MEB). The Section is divided into three regions. Each region has specific county MEQC activity assignments.

1. Offices

HEADQUARTERS

Tom Welch, Chief
Program Review Section
MS 4610
PO Box 942732
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CENTRAL REGION

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MS 4610
PO Box 942732
Sacramento, CA 94234-7320

Phone: (916) 552-9442
Fax: (916) 552-9478
E-mail: mbrown1@dhs.ca.gov

COASTAL REGION

John Lim, Chief
Coastal Program Review Region
185 Berry Street, Suite 270
San Francisco, CA 94107

Phone: 415-904-9702
Fax: 415-904-9711
E-mail: jlim@dhs.ca.gov

SOUTHERN REGION

Jose Morales, Chief
Southern Program Review Region
311 South Spring Street, Room 217
Los Angeles, CA 90013

Phone: 213-897-0980
Fax: 213-897-0976
E-mail: jmorales@dhs.ca.gov



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2. County Assignments

Most MEQC activities are handled by the PRS MEQC Regions identified below. Staff from other Regions may be involved based on the review and available resources.

<u>County</u>	<u>MEQC Region</u>	<u>County</u>	<u>MEQC Region</u>
Alameda	Coastal	Orange	Central
Alpine	Central	Placer	Central
Amador	Central	Plumas	Central
Butte	Central	Riverside	Southern
Calaveras	Central	Sacramento	Central
Colusa	Central	San Benito	Coastal
Contra Costa	Coastal	San Bernardino	Southern
Del Norte	Coastal	San Diego	Central
El Dorado	Central	San Francisco	Coastal
Fresno	Coastal	San Joaquin	Central
Glenn	Central	San Luis Obispo	Southern
Humboldt	Coastal	San Mateo	Coastal
Imperial	Central	Santa Barbara	Southern
Inyo	Southern	Santa Clara	Coastal
Kern	Southern	Santa Cruz	Coastal
Kings	Coastal	Shasta	Central
Lake	Coastal	Sierra	Central
Lassen	Central	Siskiyou	Central
Los Angeles	Southern	Solano	Coastal
Madera	Coastal	Sonoma	Coastal
Marin	Coastal	Stanislaus	Central
Mariposa	Coastal	Sutter	Central
Mendocino	Coastal	Tehama	Central
Merced	Coastal	Trinity	Central
Modoc	Central	Tulare	Coastal
Mono	Southern	Tuolumne	Coastal
Monterey	Coastal	Ventura	Southern
Napa	Coastal	Yolo	Central
Nevada	Central	Yuba	Central

