

## Medicaid State Plan Eligibility: General Information

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**State/Territory name:** California

**Transmittal Number:** CA-13-0022

**General Information:**

**Submission Title:**

short (under 100 characters) label used to identify this submission in the web application

**Description:**

**Populations Covered:**

**Mandatory Coverage:**

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Adult Group

Former Foster Care Children

**Options for Coverage:**

Individuals above 133% FPL

Optional Coverage of Parents and Other Caretaker Relatives

Reasonable Classification of Individuals under Age 21

Children with Non IV-E Adoption Assistance

Optional Targeted Low Income Children

Individuals with Tuberculosis

Independent Foster Care Adolescents

Individuals Eligible for Family Planning Services

## Medicaid State Plan Eligibility: File Management Summary

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Type of SPA	Form Code	Form Name/Description	Uploaded?
MAGI-Based Eligibility Groups	S14	AFDC Income Standard	no
MAGI-Based Eligibility Groups	S25	Mandatory: Parents and Other Caretakers	no
MAGI-Based Eligibility Groups	S28	Mandatory: Pregnant Women	no
MAGI-Based Eligibility Groups	S30	Mandatory: Infants and Children Under Age 19	no
MAGI-Based			

Eligibility Groups	S32	Mandatory: Individuals Below 133% of the FPL	no
MAGI-Based Eligibility Groups	S33	Mandatory: Former Foster Care Children up to age 26	no
MAGI-Based Eligibility Groups	S50	Optional: Individuals Above 133% of the FPL	no
MAGI-Based Eligibility Groups	S51	Optional: Optional Parents and Caretakers	no
MAGI-Based Eligibility Groups	S52	Optional: Reasonable Classifications of Individuals	no
MAGI-Based Eligibility Groups	S53	Optional: Non IV-E Adoption Assistance	no
MAGI-Based Eligibility Groups	S54	Optional: Optional Targeted Low Income Children	no
MAGI-Based Eligibility Groups	S55	Optional: Tuberculosis	no
MAGI-Based Eligibility Groups	S57	Optional: Foster Care Adolescents - Chafee	no
MAGI-Based Eligibility Groups	S59	Optional: Family Planning	no
Eligibility Process	S94	Single streamlined application or alternative, Renewals, Coordination for enrollment and eligibility (agreements with Exchanges)	yes
MAGI Income Methodology	S10	Designates the income options the state is electing in 2014 (e.g. how pregnant women are counted, reasonably predictable changes in income, cash support, how full-time students are counted)	no
Single State Agency	A1-3	Addresses single state agencies delegation of appeals and determinations	no
Residency	S88	State affirms residency regulations and addresses interstate agreements and temporary absence	no
Citizenship & Immigration Status	S89	State affirms citizenship regulations, specifies reasonable opportunity options, and specifies policy options related to immigrant eligibility	no
Hospital Presumptive Eligibility	S21	State specifies options for presumptive eligibility conducted by hospitals	no

## Submission - Tribal Input

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State/Territory name: California  
 Transmittal Number: CA-13-0022

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.

This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian

**Organizations.**

The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.

*Complete the following information regarding any tribal consultation conducted with respect to this submission:*

**Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:**

**Indian Tribes**

<b>Indian Tribes</b>	
Name of Indian Tribe:	
Date of consultation:	<i>(mm/dd/yyyy)</i>
Method/Location of consultation:	

**Indian Health Programs**

<b>Indian Health Programs</b>	
Name of Indian Health Programs:	
Date of consultation:	<i>(mm/dd/yyyy)</i>
Method/Location of consultation:	

**Urban Indian Organization**

<b>Urban Indian Organizations</b>	
Name of Urban Indian Organization:	
Date of consultation:	<i>(mm/dd/yyyy)</i>
Method/Location of consultation:	

**The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.**

<b>Document</b>	
Please provide a short description of this support document:	
<b>Uploaded Document Name:</b>	
Please provide a short description of this support document:	

**Uploaded Document Name:**

**Indicate the key issues raised in Indian consultative activities:**

**Access**

**Summarize Comments**

**Summarize Response**

**Quality**

**Summarize Comments**

**Summarize Response**

**Cost**

**Summarize Comments**

**Summarize Response**

**Payment methodology**

**Summarize Comments**

**Summarize Response**

**Eligibility**

**Summarize Comments**

**Summarize Response**

**Benefits**

**Summarize Comments**

**Summarize Response**

**Service delivery**

**Summarize Comments**

**Summarize Response**

**Other Issue**

**Medicaid State Plan Eligibility: Summary Page (CMS 179)**

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**State/Territory name:** California

**Transmittal Number:**

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

**Proposed Effective Date**

(mm/dd/yyyy)

**Federal Statute/Regulation Citation**

**Federal Budget Impact**

	<b>Federal Fiscal Year</b>	<b>Amount</b>
<b>First Year</b>	\$	
<b>Second Year</b>	\$	

**Subject of Amendment**

**Governor's Office Review**

**Governor's office reported no comment**

**Comments of Governor's office received**

Describe:

**No reply received within 45 days of submittal**

**Other, as specified**

Describe:

**Signature of State Agency Official**

**Submitted By:**

**Kathryn Waje**

**Date Submitted:**

**Sep 11, 2013**