Medi-Cal Explained FACT SHEET

California's Medicaid State Plan Amendments

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What Is a Medicaid State Plan?

Every state that participates in the Medicaid program must create a State Plan that describes the scope of its Medicaid program, and must seek federal approval for that plan. The State Plan serves as a contractual agreement between the state Medicaid agency and the federal agency that oversees the Medicaid program, the Centers for Medicare & Medicaid Services (CMS). CMS reviews and approves the plan and determines if the services described are eligible for Federal Financial Participation, also known as matching funds.[1]

Title XIX of the Social Security Act outlines what must be included in a State Plan.[2] Among other things, it must describe how the state will:

- Create an agency to administer the Medicaid program
- Fund its share of Medicaid services
- Serve all geographic areas of the state
- Grant rights to Medicaid beneficiaries who are denied services
- Deliver care in accordance with quality standards

The plan also must define who is eligible for Medicaid services, as federal rules require that certain populations, such as children and pregnant women, be included. States may choose to cover additional populations. The State Plan also describes required and optional services the state Medicaid agency will provide to beneficiaries.

California's current State Plan and all State Plan Amendments (see below) submitted to and approved by CMS to date are available at www.dhcs.ca.gov.

What Is in California's Medicaid State Plan?

The plan has eight sections: Single State Agency, Coverage and Eligibility, Services, Administration, Personnel Administration, Financial Administration, General Provisions, and MAGI-Based Income Methodologies.

What Is a State Plan Amendment?

When a state wants to substantially change how it operates its Medicaid program, it must apply to change its State Plan by submitting a State Plan Amendment (SPA) to CMS for approval. The State Plan describes the types of changes that warrant a SPA. SPAs may be driven by changes in federal law, state law, or state policy. For example, if a state wants to adjust a specific payment methodology included in the State Plan, it must submit a SPA. When a state decides to discontinue an optional Medicaid benefit, it must likewise submit a SPA. Note that not every change to the Medi-Cal

program requires a SPA; the state also implements changes through other means. For example, the California Department of Health Care Services (DHCS), which oversees Medi-Cal, released an "All Plan Letter"[3] announcing changes to how Medi-Cal health plans must distribute information to enrollees. This change in policy and operations did not require a SPA.

There is no limit to the number of SPAs a state may submit, nor is there a specific time frame during which it must submit SPAs. By September 2019, California had submitted 33 SPAs to CMS for calendar year 2019, and 16 had been approved.[4] Examples of recent California SPAs include a request to authorize the Health Homes Program[5] for Med-Cal beneficiaries with serious mental illness, and a proposal to set reimbursement rates for radiology services.[6] Any proposed SPA must be posted publicly by DHCS before it is submitted to CMS for approval.

What Is the Difference Between a State Plan Amendment and a Medicaid Waiver?

While both a SPA and a waiver allow a state Medicaid program to change the way it delivers care and services, they differ in several key ways. First, a waiver[7] is generally used to test an innovative programmatic or policy change to see if it has the desired outcome, such as reductions in cost or avoidable utilization of services. A SPA is not considered a test, but rather a mechanism to solidify a policy or program change. Second, waivers are usually approved for a specific duration such as five years, though they may be renewed, and must be budget neutral — that is, not cost more than traditional Medicaid services. By contrast, SPAs generally have no end date (unless states request them) and do not have to show budget neutrality.[8] Waivers may limit the population and geographic areas they serve; SPAs must cover all beneficiaries statewide. Last, waivers may be restricted to a certain number of available slots and may have waiting lists for those slots; SPAs may not impose these kinds of limitations. If a state eventually determines a waiver to be successful and wants to include the services in its State Plan, it may submit the program as a SPA. An example is the In-Home Supportive Services (IHSS) Plus waiver that was transitioned to the IHSS Plus Program in September 2009 via a SPA.[9]

What Is the Process and Timeline for State Plan Amendments?

Once the state submits a SPA proposal, CMS has 90 days to make a decision about approving it. However, if CMS requests additional information about the SPA, the timeline is paused until the new information is received.[10] In some instances, SPAs can generate quite a bit of negotiation between the state and CMS, with information requests and responses stretching into years and with CMS requesting modifications to the SPA proposal. Occasionally a SPA is withdrawn; for example, a California SPA proposal to cover certain therapeutic health services for foster youth was subsequently deemed unnecessary and withdrawn because the state determined that the proposed services were already required per the State Plan.[11] Once CMS approves a SPA, the change is retroactive to the submission date.

Prop 56 Physician Payments State Plan Amendment

- In November 2016 voters passed Proposition 56, the "California Healthcare, Research, and Prevention Tobacco Tax Act," which raised taxes on cigarettes and tobacco products.
- Additional legislation directed some Prop 56–generated funds to Medi-Cal to increase funding for existing programs.
- DHCS developed a one-year supplemental payment program directing Prop 56 funds to physicians providing specific services to Medi-Cal beneficiaries.
- Because the program changed previously approved payment methodologies within the State Plan, DHCS submitted a State Plan Amendment.
- SPA 17-030 was submitted September 28, 2017, and approved by CMS December 5, 2017, for qualified physician services rendered from July 1, 2017, through June 30, 2018.
- SPA 18-0003 extended the payment program from July 1, 2018, through June 30, 2019.
- SPA 19-0021 extended the program from July 1, 2019, through December 31, 2021.

Endnotes

1. See CHCF publication *Medi-Cal Explained Fact Sheet: The Medi-Cal Budget Process* for more information on matching funds at www.chcf.org.
2. "Compilation of the Social Security Laws: State Plans for Medical Assistance," Social Security Administration, n.d., www.ssa.gov.
3. Michelle Retke (chief, Managed Care Operation Division, DHCS) to all Medi-Cal Managed Care Plans, all-plan letter 19-003, California Dept. of Health Care Services, May 2, 2019, www.dhcs.ca.gov (PDF).
4. Proposed, pending, approved, and withdrawn SPAs can be viewed on the DHCS website at www.dhcs.ca.gov.
5. Approval of California State Plan Amendment CA-19-0001 "California Health Homes Program," www.dhcs.ca.gov (PDF).
6. Approval of California State Plan Amendment CA-19-0003 "Reimbursement Rates for Radiology Services," www.dhcs.ca.gov (PDF).
7. See October 2019 CHCF publication *Medi-Cal Explained Fact Sheet: Medicaid Waivers in California* that describes Medi-Cal waivers at www.chcf.org.
8. Medicaid and CHIP Payment and Access Commission (MACPAC): State Plan www.macpac.gov.
9. Approval of California State Plan Amendment CA-09-006, www.dhcs.ca.gov (PDF).
10. Brian Neale, "State Plan Amendment and 1915 Waiver Process Improvements to Improve Transparency and Efficiency and Reduce Burden," CMS, November 6, 2017, www.medicaid.gov (PDF).
11. Toby Douglas (director, DHCS) to Gloria Nagle (assoc. regional administrator, CMS), June 18, 2014, www.dhcs.ca.gov (PDF).

Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.