AMENDED IN ASSEMBLY MARCH 18, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 2077

Introduced by Assembly Members Burke and Bonilla

February 17, 2016

An act *to amend Section 14005.37 of, and to add Section 15927 to, the Welfare and Institutions Code,* relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 2077, as amended, Burke. Health Care Eligibility, Enrollment, and Retention Act.

Existing law establishes various programs to provide health care coverage to persons with limited financial resources, including the Medi-Cal program and the state's children's health insurance program (CHIP). Existing law establishes the California Health Benefit Exchange (Exchange), pursuant to the federal Patient Protection and Affordable Care Act, and specifies the duties and powers of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans through the Exchange.

Existing law, the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, requires an individual to have the option to apply for insurance affordability programs in person, by mail, online, by telephone, or by other commonly available electronic means. Existing law defines "insurance affordability programs" to include the Medi-Cal program, CHIP, and a program that makes available to qualified individuals coverage in a qualified health benefit plan through the Exchange with advance payment of the premium tax credit established under a specified provision of the Internal Revenue ~~Code.~~ *Code and a*

cost-sharing reduction under a specified provision of federal law. During the processing of an application, renewal, or a transition due to a change in circumstances, existing law requires an entity making eligibility determinations for an insurance affordability program to ensure that an eligible applicant and recipient of those programs that meets all program eligibility requirements and complies with all necessary requirements for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary.

This bill would ~~declare the intent of the Legislature to enact legislation that would establish procedures to ensure that individuals move between Medi-Cal and the Exchange without any breaks in coverage as required under the provision described above.~~ *establish procedures to ensure that eligible recipients of insurance affordability programs move between the Medi-Cal program and other insurance affordability programs without any breaks in coverage as required under the provision described above. The bill would require, among other things, an individual's case to be run through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERs) if an individual enrolled in a qualified health benefit plan through the Exchange reports a change in circumstances or is reevaluated for eligibility, and there is a change in circumstances affecting his or her eligibility for an insurance affordability program. The bill would require the individual's case file to be sent to his or her county of residence within 3 business days if CalHEERs receives information indicating that the individual is newly eligible for Medi-Cal. The bill would prohibit the county from treating the receipt of a case file under these circumstances as a new Medi-Cal application, and would require those case files to be processed by the county according to specified timelines. The bill would require the county to issue to those individuals who are newly eligible for Medi-Cal a notice that contains specified information, including instructions on how to select a Medi-Cal managed care health plan. The bill would establish different enrollment procedures to be followed for those counties that provide Medi-Cal services under the two-plan model or the geographic managed care plan model, or a county organized health system, as specified.*

The bill would generally prohibit Medi-Cal benefits from being terminated until at least 30 days after the county sends the notice of action terminating Medi-Cal eligibility, and would require the notice

of action to inform the individual of the date by which he or she must select and enroll in a qualified health benefit plan through the Exchange, as specified.

By modifying the enrollment process under the Medi-Cal program, thereby increasing the responsibilities of counties in the administration of the Medi-Cal program, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the ~~Legislature to enact legislation that would~~ *Legislature, with the enactment of this act, to* establish procedures to ensure that individuals move between Medi-Cal and the California Health Benefit Exchange without any breaks in coverage as required under subdivision (h) of Section 15926 of the Welfare and Institutions Code.

SEC. 2. Section 14005.37 of the Welfare and Institutions Code is amended to read:

14005.37. (a) Except as provided in Section 14005.39, a county shall perform redeterminations of eligibility for Medi-Cal beneficiaries every 12 months and shall promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits. The procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries.

(b) Loss of eligibility for cash aid under that program shall not result in a redetermination under this section unless the reason for the loss of eligibility is one that would result in the need for a redetermination for a person whose eligibility for Medi-Cal under

Section 14005.30 was determined without a concurrent determination of eligibility for cash aid under the CalWORKs program.

(c) A loss of contact, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, shall require a prompt redetermination according to the procedures set forth in this section.

(d) Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section and a beneficiary's Medi-Cal eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under any basis and due process rights guaranteed under this division have been met. For the purposes of this subdivision, for a beneficiary who is subject to the use of MAGI-based financial methods, the determination of whether the beneficiary is eligible for Medi-Cal benefits under any basis shall include, but is not limited to, a determination of eligibility for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods only if either of the following occurs:

~~(A)~~

(1) The county assesses the beneficiary as being potentially eligible under a program that is exempt from the use of MAGI-based financial methods, including, but not limited to, on the basis of age, blindness, disability, or the need for long-term care services and supports.

~~(B)~~

(2) The beneficiary requests that the county determine whether he or she is eligible for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods.

(e) (1) For purposes of acquiring information necessary to conduct the eligibility redeterminations described in this section, a county shall gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary. Sources for these efforts shall include information contained in the beneficiary's file or other information, including more recent information available to the county, including, but not limited to, Medi-Cal, CalWORKs, and CalFresh case files of the

beneficiary or of any of his or her immediate family members, which are open, or were closed within the last 90 days, information accessed through any databases accessed under Sections 435.948, 435.949, and 435.956 of Title 42 of the Code of Federal Regulations, and wherever feasible, other sources of relevant information reasonably available to the county or to the county via the department.

(2) In the case of an annual redetermination, if, based upon information obtained pursuant to paragraph (1), the county is able to make a determination of continued eligibility, the county shall notify the beneficiary of both of the following:

(A) The eligibility determination and the information it is based on.

(B) That the beneficiary is required to inform the county via the Internet, by telephone, by mail, in person, or through other commonly available electronic means, in counties where such electronic communication is available, if any information contained in the notice is inaccurate but that the beneficiary is not required to sign and return the notice if all information provided on the notice is accurate.

(3) The county shall make all reasonable efforts not to send multiple notices during the same time period about eligibility. The notice of eligibility renewal shall contain other related information such as if the beneficiary is in a new Medi-Cal program.

(4) In the case of a redetermination due to a change in circumstances, if a county determines that the change in circumstances does not affect the beneficiary's eligibility status, the county shall not send the beneficiary a notice unless required to do so by federal law.

(f) (1) In the case of an annual eligibility redetermination, if the county is unable to determine continued eligibility based on the information obtained pursuant to paragraph (1) of subdivision (e), the beneficiary shall be so informed and shall be provided with an annual renewal form, at least 60 days before the beneficiary's annual redetermination date, that is prepopulated with information that the county has obtained and that identifies any additional information needed by the county to determine eligibility. The form shall include all of the following:

(A) The requirement that he or she provide any necessary information to the county within 60 days of the date that the form is sent to the beneficiary.

(B) That the beneficiary may respond to the county via the Internet, by mail, by telephone, in person, or through other commonly available electronic means if those means are available in that county.

(C) That if the beneficiary chooses to return the form to the county in person or via mail, the beneficiary shall sign the form in order for it to be considered complete.

(D) The telephone number to call in order to obtain more information.

(2) The county shall attempt to contact the beneficiary via the Internet, by telephone, or through other commonly available electronic means, if those means are available in that county, during the 60-day period after the prepopulated form is mailed to the beneficiary to collect the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response.

(3) If the beneficiary has not provided any response to the written request for information sent pursuant to paragraph (1) within 60 days from the date the form is sent, the county shall terminate his or her eligibility for Medi-Cal benefits following the provision of timely notice.

(4) If the beneficiary responds to the written request for information during the 60-day period pursuant to paragraph (1) but the information provided is not complete, the county shall follow the procedures set forth in paragraph (3) of subdivision (g) to work with the beneficiary to complete the information.

(5) (A) The form required by this subdivision shall be developed by the department in consultation with the counties and representatives of eligibility workers and consumers.

(B) For beneficiaries whose eligibility is not determined using MAGI-based financial methods, the county may use existing renewal forms until the state develops prepopulated renewal forms to provide to beneficiaries. The department shall develop prepopulated renewal forms for use with beneficiaries whose eligibility is not determined using MAGI-based financial methods by January 1, 2015.

(g) (1) In the case of a redetermination due to change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility pursuant to subdivision (e), the county shall send to the beneficiary a form that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. The county shall only request information related to the change in circumstances. The county shall not request information or documentation that has been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The county shall only request information for nonapplicants necessary to make an eligibility determination or for a purpose directly related to the administration of the state Medicaid plan. The form shall advise the individual to provide any necessary information to the county via the Internet, by telephone, by mail, in person, or through other commonly available electronic means and, if the individual will provide the form by mail or in person, to sign the form. The form shall include a telephone number to call in order to obtain more information. The form shall be developed by the department in consultation with the counties, representatives of consumers, and eligibility workers. A Medi-Cal beneficiary shall have 30 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in paragraph (2), failure to respond prior to the end of this 30-day period shall not impact his or her Medi-Cal eligibility.

(2) If the purpose for a redetermination under this section is a loss of contact with the Medi-Cal beneficiary, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, a return of the form described in this subdivision marked as undeliverable shall result in an immediate notice of action terminating Medi-Cal eligibility.

(3) During the 30-day period after the date of mailing of a form to the Medi-Cal beneficiary pursuant to this subdivision, the county shall attempt to contact the beneficiary by telephone, in writing, or other commonly available electronic means, in counties where such electronic communication is available, to request the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response. If the beneficiary does not supply the necessary

information to the county within the 30-day limit, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

(h) Beneficiaries shall be required to report any change in circumstances that may affect their eligibility within 10 calendar days following the date the change occurred.

(i) If within 90 days of termination of a Medi-Cal beneficiary's eligibility or a change in eligibility status pursuant to this section, the beneficiary submits to the county a signed and completed form or otherwise provides the needed information to the county, eligibility shall be redetermined by the county and if the beneficiary is found eligible, or the beneficiary's eligibility status has not changed, whichever applies, the termination shall be rescinded as though the form were submitted in a timely manner.

(j) If the information available to the county pursuant to the redetermination procedures of this section does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met.

(k) The department shall, with the counties and representatives of consumers, including those with disabilities, and Medi-Cal eligibility workers, develop a timeframe for redetermination of Medi-Cal eligibility based upon disability, including ex parte review, the redetermination forms described in subdivisions (f) and (g), timeframes for responding to county or state requests for additional information, and the forms and procedures to be used. The forms and procedures shall be as consumer-friendly as possible for people with disabilities. The timeframe shall provide a reasonable and adequate opportunity for the Medi-Cal beneficiary to obtain and submit medical records and other information needed to establish eligibility for Medi-Cal based upon disability.

(*l*) The county shall consider blindness as continuing until the reviewing physician determines that a beneficiary's vision has improved beyond the applicable definition of blindness contained in the plan.

(m) The county shall consider disability as continuing until the review team determines that a beneficiary's disability no longer meets the applicable definition of disability contained in the plan.

(n) In the case of a redetermination due to a change in circumstances, if a county determines that the beneficiary remains eligible for Medi-Cal benefits, the county shall begin a new 12-month eligibility period.

(o) *(1)* For individuals determined ineligible for Medi-Cal by a county following the redetermination procedures set forth in this section, the county shall determine eligibility for other insurance affordability programs and if the individual is found to be eligible, the county shall, as appropriate, transfer the individual's electronic account to other insurance affordability programs via a secure electronic interface.

(2) If the individual is eligible to enroll in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code under any insurance affordability program, Medi-Cal benefits shall not be terminated until at least 30 days after the county sends the notice of action terminating Medi-Cal eligibility. The notice of action shall inform the individual of the date by which he or she must select and enroll in a qualified health plan through the Exchange to avoid being uninsured. If the individual has effectuated his or her enrollment in a qualified health plan through the Exchange before the termination date specified in the notice, Medi-Cal eligibility shall be terminated as of the date of enrollment in the qualified health plan.

(p) Any renewal form or notice shall be accessible to persons who are limited-English proficient and persons with disabilities consistent with all federal and state requirements.

(q) The requirements to provide information in subdivisions (e) and (g), and to report changes in circumstances in subdivision (h), may be provided through any of the modes of submission allowed in Section 435.907(a) of Title 42 of the Code of Federal Regulations, including an Internet Web site identified by the department, telephone, mail, in person, and other commonly available electronic means as authorized by the department.

(r) Forms required to be signed by a beneficiary pursuant to this section shall be signed under penalty of perjury. Electronic signatures, telephonic signatures, and handwritten signatures transmitted by electronic transmission shall be accepted.

(s) For purposes of this section, "MAGI-based financial methods" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, and as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation

Act of 2010 (Public Law 111-152), and any subsequent amendments.

(t) When contacting a beneficiary under paragraphs (2) and (4) of subdivision (f), and paragraph (3) of subdivision (g), a county shall first attempt to use the method of contact identified by the beneficiary as the preferred method of contact, if a method has been identified.

(u) The department shall seek federal approval to extend the annual redetermination date under this section for a three-month period for those Medi-Cal beneficiaries whose annual redeterminations are scheduled to occur between January 1, 2014, and March 31, 2014.

(v) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(w) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

~~(x) This section shall become operative on January 1, 2014.~~

SEC. 3. Section 15927 is added to the Welfare and Institutions Code, immediately following Section 15926, to read:

15927. (a) If an individual enrolled in a qualified health plan through the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code reports a change in circumstances, goes through the renewal process, or is reevaluated for eligibility and there is a change affecting his or her eligibility for any insurance affordability program, the individual's case shall be run through the California Healthcare Eligibility, Enrollment, and Retention System

(CalHEERS) developed under Section 15926. If CalHEERS receives information indicating that an individual who has been enrolled in a qualified health plan through the Exchange is newly eligible for Medi-Cal, the individual's case file shall be sent to his or her county of residence within three business days.

(b) (1) If the county of residence receives a case file regarding an individual described in subdivision (a) who is newly eligible for Medi-Cal, the county shall not treat this as a new Medi-Cal application.

(A) Case files received by the county prior to the 15th day of the month shall be processed for final Medi-Cal eligibility by the county by the end of that month.

(B) Case files received by the county after the 15th day of the month shall be processed for final Medi-Cal eligibility by the 15th day of the following month.

(2) For individuals described in subdivision (a) who are newly eligible for Medi-Cal, the county shall issue a notice at least 15 days before the individual's enrollment in a qualified health plan through the Exchange ends that advises the individual of all of the following information:

(A) He or she will be enrolled into Medi-Cal.

(B) Instructions on how to select a Medi-Cal managed care health plan.

(C) His or her right to appeal an action related to the individual's eligibility for or enrollment in an insurance affordability program pursuant to Section 100506.1 of the Government Code.

(D) Instructions on how to request continued enrollment in a qualified health benefit plan pending the outcome of his or her appeal of an action related to the individual's eligibility for or enrollment in an insurance affordability program.

(3) If information is needed by the county to verify income, the county shall follow the procedures set forth in subdivisions (f) and (g) of Section 14005.37 to obtain that information.

(c) An individual described in subdivision (a) who is newly eligible for Medi-Cal shall be enrolled in the Medi-Cal program according to the following procedures:

(1) (A) In a county that provides Medi-Cal services under the two-plan model or the geographic managed care plan model pursuant to Article 2.7 (commencing with Section 14087.3), Article

2.81 (commencing with Section 14087.96), and Article 2.91 (commencing with Section 14089), the individual shall be enrolled in a Medi-Cal managed care plan according to either of the following:

(i) If the qualified health plan the individual was enrolled in through the Exchange is an available Medi-Cal managed care plan in his or her county and that plan has the same or substantially similar provider network, the individual shall be assigned to that plan.

(ii) The individual shall be assigned to a plan using the usual Medi-Cal managed care default algorithm.

(B) The 15-day notice issued to the individual newly eligible for Medi-Cal shall advise him or her of all of the following information:

(i) The Medi-Cal managed care plan to which he or she will be assigned if the individual does not take any action.

(ii) The individual may choose any available Medi-Cal managed care plan.

(iii) A description of the Medi-Cal managed care plans available in his or her county.

(iv) Instructions on how the individual may change Medi-Cal managed care plans.

(2) In a county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5), the individual shall be enrolled into the county organized health system plan on the first date of Medi-Cal coverage and shall be sent the provider directory for the managed care plan.

SEC. 4. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

O