

**Senate Bill No. 87**

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Passed the Senate August 31, 2000

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*Secretary of the Senate*

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Passed the Assembly August 30, 2000

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*Chief Clerk of the Assembly*

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This bill was received by the Governor this \_\_\_\_\_ day  
of \_\_\_\_\_, 2000, at \_\_\_\_\_ o'clock \_\_\_\_M.

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*Private Secretary of the Governor*

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## CHAPTER \_\_\_\_\_

An act to amend Section 14005.81 of, and to add Sections 14005.31, 14005.32, 14005.33, 14005.34, 14005.35, 14005.36, 14005.37, 14005.38, and 14005.39 to, the Welfare and Institutions Code, relating to health.

## LEGISLATIVE COUNSEL'S DIGEST

SB 87, Escutia. Medi-Cal: eligibility.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

Existing law creates various bases for the establishment of Medi-Cal eligibility.

This bill would make changes in Medi-Cal eligibility criteria and procedures in instances when eligibility on one basis has terminated. The bill would provide for the transfer of a Medi-Cal beneficiary's benefits to an appropriate transitional Medi-Cal program, under specified circumstances. It would also provide for eligibility redetermination procedures when a Medi-Cal beneficiary's circumstances change so as to affect his or her eligibility generally, and specifically in cases in which the CalWORKs benefits of Medi-Cal beneficiaries have been terminated.

Because each county is required to administer Medi-Cal eligibility determination provisions, the bill would constitute a state-mandated local program.

The bill would require that the foregoing provisions be implemented not later than July 1, 2001, but only to the extent that federal financial participation is available.

The bill would require the department, in consultation with specified parties, to conduct a study of the feasibility of adopting a mechanism whereby, to the extent federal financial participation is available, a Medi-Cal managed care plan shall be notified whenever the eligibility of a Medi-Cal beneficiary is being redetermined.



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, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed \$1,000,000 statewide and other procedures for claims whose statewide costs exceed \$1,000,000.

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.

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

SECTION 1. Section 14005.31 is added to the Welfare and Institutions Code, to read:

14005.31. (a) (1) Subject to paragraph (2), for any person whose eligibility for benefits under Section 14005.30 has been determined with a concurrent determination of eligibility for cash aid under Chapter 2 (commencing with Section 11200), loss of eligibility or termination of cash aid under Chapter 2 (commencing with Section 11200) shall not result in a loss of eligibility or termination of benefits under Section 14005.30 absent the existence of a factor that would result in loss of eligibility for benefits under Section 14005.30 for a person whose eligibility under Section 14005.30 was determined without a concurrent determination of eligibility for benefits under Chapter 2 (commencing with Section 11200).

(2) Notwithstanding paragraph (1), a person whose eligibility would otherwise be terminated pursuant to that paragraph shall not have his or her eligibility terminated until the transfer procedures set forth in Section 14005.32 or the redetermination procedures set forth in Section 14005.37 and all due process requirements have been met.

(b) The department shall, in consultation with the counties and representatives of consumers, managed



care plans, and Medi-Cal providers, prepare a simple, clear, consumer-friendly notice, which shall be used by the counties in order to inform Medi-Cal beneficiaries whose eligibility for cash aid under Chapter 2 (commencing with Section 11200) has ended, but whose eligibility for benefits under Section 14005.30 continues pursuant to subdivision (a), that their benefits will continue. To the extent feasible, the notice shall be sent out at the same time as the notice of discontinuation of cash aid, and shall include all of the following:

(1) A statement that Medi-Cal benefits will continue even though cash aid under the CalWORKs program has been terminated.

(2) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(3) A statement that the Medi-Cal beneficiary does not need to fill out monthly or quarterly status reports in order to remain eligible for Medi-Cal, but shall be required to submit an annual reaffirmation form. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that he or she should review his or her circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

(4) A statement describing the responsibility of the Medi-Cal beneficiary to report to the county, within 10 days, significant changes that may affect eligibility.

(5) A telephone number to call for more information.

(6) A statement that the Medi-Cal beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's eligibility workers can be contacted.

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social



Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations 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. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 2. Section 14005.32 is added to the Welfare and Institutions Code, to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30, but is eligible for benefits under this chapter pursuant to other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program. Eligibility under Section 14005.30 shall continue until the transfer is complete.

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with Section 11200) has been terminated.

(B) The name of the program under which benefits will continue, and an explanation of that program.

(C) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in



existence for receipt of cash aid under the CalWORKs program.

(D) A statement that the Medi-Cal beneficiary does not need to fill out monthly or quarterly status reports in order to remain eligible for Medi-Cal, but shall be required to submit an annual reaffirmation form. In addition, if the person or persons to whom the notice is directed has been found eligible for transitional Medi-Cal as described in Section 14005.8, 14005.81, or 14005.85, the statement shall explain the reporting requirements and duration of benefits under those programs, and shall further explain that, at the end of the duration of these benefits, a redetermination, as provided for in Section 14005.37 shall be conducted to determine whether benefits are available under any other provision of law.

(E) A statement describing the beneficiary's responsibility to report to the county, within 10 days, significant changes that may affect eligibility or share of cost.

(F) A telephone number to call for more information.

(G) A statement that the beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's Medi-Cal eligibility workers can be contacted.

(b) No later than September 1, 2001, the department shall submit a federal waiver application seeking authority to eliminate the reporting requirements imposed by transitional medicaid under Section 1925 of the federal Social Security Act (Title 42 U.S.C. Sec. 1396r-6).

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means



of all county letters or similar instructions. Thereafter, the department shall adopt regulations 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. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 3. Section 14005.33 is added to the Welfare and Institutions Code, to read:

14005.33. (a) If a Medi-Cal beneficiary's Medi-Cal eligibility worker is changed, notice shall be sent to the beneficiary within 10 days of the change. This notice shall include the worker's name, address, and telephone number, and the beneficiary's Medi-Cal case number, and hours during which the county's Medi-Cal eligibility workers may be contacted by the beneficiary.

(b) This section shall be implemented on or before July 1, 2001.

SEC. 4. Section 14005.34 is added to the Welfare and Institutions Code, to read:

14005.34. (a) For an individual whose cash aid was terminated pursuant to Chapter 2 (commencing with Section 11200), but whose Medi-Cal eligibility was continued either pursuant to subdivision (a) of Section 14005.31 or pursuant to a transfer of eligibility under Section 14005.32, the Medi-Cal beneficiary's annual reaffirmation date under Section 14012 shall be no earlier than 12 months from the date on which the most recent annual CalWORKs cash aid eligibility determination was conducted, or, if no such determination was conducted, 12 months from the date cash aid was granted.

(b) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means



of all county letters or similar instructions. Thereafter, the department shall adopt regulations 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. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 5. Section 14005.35 is added to the Welfare and Institutions Code, to read:

14005.35. (a) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall study the feasibility of adopting a mechanism whereby, to the extent federal financial participation is available, a Medi-Cal managed care plan shall be notified whenever the eligibility of a Medi-Cal beneficiary enrolled in that plan is being redetermined, including notice of the date upon which any forms must be submitted to the county by the beneficiary.

SEC. 6. Section 14005.36 is added to the Welfare and Institutions Code, to read:

14005.36. (a) The county shall undertake outreach efforts to beneficiaries receiving benefits under this chapter, in order to maintain the most up-to-date home addresses, telephone numbers, and other necessary contact information, and to encourage and assist with timely submission of the annual reaffirmation form, and, when applicable, transitional Medi-Cal program reporting forms and to facilitate the Medi-Cal redetermination process when one is required as provided in Section 14005.37. In implementing this subdivision, a county may collaborate with community-based organizations, provided that confidentiality is protected.

(b) The department shall encourage and facilitate efforts by managed care plans to report updated beneficiary contact information to counties.

(c) The department and each county shall incorporate, in a timely manner, updated contact information received from managed care plans pursuant



to subdivision (b) into the beneficiary's Medi-Cal case file and into all systems used to inform plans of their beneficiaries' enrollee status. Updated Medi-Cal beneficiary contact information shall be limited to the beneficiary's telephone number, change of address information, and change of name. The county may attempt to verify that the information it receives from the plan is accurate before updating the beneficiary's case file. The department shall develop a consent form that may be used by the counties to record the beneficiary's consent to use the information received from a managed care plan to update the beneficiary's file.

(d) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations 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. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 7. Section 14005.37 is added to the Welfare and Institutions Code, to read:

14005.37. (a) Except as provided in Section 14005.39, whenever a county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits, the county shall promptly redetermine eligibility. 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. A Medi-Cal beneficiary's 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 under any basis and due process rights guaranteed under this division have been met.

(e) For purposes of acquiring information necessary to conduct the eligibility determinations described in subdivisions (a) to (d), inclusive, a county shall make every reasonable effort to 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, but are not limited to, Medi-Cal, CalWORKs, and Food Stamp Program case files of the beneficiary or of any of his or her immediate family members, which are open or were closed within the last 45 days, and wherever feasible, other sources of relevant information reasonably available to the counties.

(f) If a county cannot obtain information necessary to redetermine eligibility pursuant to subdivision (e), the county shall attempt to reach the beneficiary by telephone in order to obtain this information, either directly or in collaboration with community-based organizations so long as confidentiality is protected.

(g) If a county's efforts pursuant to subdivisions (e) and (f) to obtain the information necessary to redetermine eligibility have failed, the county shall send



to the beneficiary a form, which shall highlight the information needed to complete the eligibility determination. 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 form shall be accompanied by a simple, clear, consumer-friendly cover letter, which shall explain why the form is necessary, the fact that it is not necessary to be receiving CalWORKs benefits to be receiving Medi-Cal benefits, the fact that receipt of Medi-Cal benefits does not count toward any time limits imposed by the CalWORKs program, the various bases for Medi-Cal eligibility, including disability, and the fact that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. The form and the cover letter shall be developed by the department in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers. A Medi-Cal beneficiary shall have no less than 20 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in subdivision (h), failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.

(h) 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 subdivision (g) marked as undeliverable shall result in an immediate notice of action terminating Medi-Cal eligibility.

(i) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), a beneficiary does not submit the completed form to the county, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the



reasons for that determination, unless the beneficiary submits a completed form prior to the end of the 10-day period.

(j) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary submits an incomplete form, the county shall attempt to contact the beneficiary by telephone and in writing to request the necessary information. If the beneficiary does not supply the necessary information to the county within 10 days from the date the county contacts the beneficiary in regard to the incomplete form, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

(k) If, within 30 days of termination of a Medi-Cal beneficiary's eligibility pursuant to subdivision (h), (i), or (j), the beneficiary submits to the county a completed form, eligibility shall be determined as though the form was submitted in a timely manner and if a beneficiary is found eligible, the termination under subdivision (h), (I), or (j) shall be rescinded.

(l) If the information reasonably available to the county pursuant to the redetermination procedures of subdivisions (d), (e), (g), and (m) does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met.

(m) The department shall, with the counties and representatives of consumers, including those with disabilities, and Medi-Cal providers, develop a timeframe for redetermination of Medi-Cal eligibility based upon disability, including ex parte review, the redetermination form described in subdivision (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.



(n) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(o) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations 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. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 8. Section 14005.38 is added to the Welfare and Institutions Code, to read:

14005.38. To the extent feasible, the department shall use the redetermination form required by subdivision (g) of Section 14005.37 as the annual reaffirmation form.

SEC. 9. Section 14005.39 is added to the Welfare and Institutions Code, to read:

14005.39. (a) If a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits shall be terminated without a redetermination under Section 14005.37.

(b) Whenever Medi-Cal eligibility is terminated without a redetermination, as provided in subdivision (a), the Medi-Cal eligibility worker shall document that fact or event causing the eligibility termination in the beneficiary's file, along with a written certification that a full redetermination could not result in a finding of Medi-Cal eligibility. Following this written certification, a notice of action specifying the basis for termination of Medi-Cal eligibility shall be sent to the beneficiary.

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial



participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations 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. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 10. Section 14005.81 of the Welfare and Institutions Code is amended to read:

14005.81. (a) Effective October 1, 1998, in addition to the two six-month periods of transitional Medi-Cal benefits provided in Section 14005.8, the state shall fund and provide one additional 12-month period of transitional Medi-Cal to persons age 19 years and older who have received 12 months of transitional Medi-Cal under Section 14005.8 and who continue to meet the requirements applicable to the additional six-month extension period provided for in Section 14005.8, except that once a beneficiary has been determined eligible for an additional 12 months of Medi-Cal benefits under this section, the beneficiary shall not be required to submit the status reports imposed by federal law. The benefits provided under this section shall commence on the day following the last day of receipt of benefits under Section 14005.8.

(b) In the case of an alien who has received 12 months of transitional Medi-Cal under Section 14005.8, the benefits provided under this section shall be limited to those benefits that would be available to that person under Section 14005.8.

(c) It is the intent of the Legislature that the department seek a mechanism for securing federal



financial participation in connection with pregnancy-related benefits provided under this section.

SEC. 11. Notwithstanding Section 17610 of the Government Code, 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. If the statewide cost of the claim for reimbursement does not exceed one million dollars (\$1,000,000), reimbursement shall be made from the State Mandates Claims Fund.



Approved \_\_\_\_\_, 2000

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*Governor*

