# SENATE COMMITTEE ON HEALTH
**Senator Ed Hernandez, O.D., Chair**

**BILL NO:** **SB X1 1**
**AUTHOR:** **Hernandez and Steinberg**
**INTRODUCED:** **January 28, 2013**
**HEARING DATE:** **February 27, 2013**
**CONSULTANT:** **Bain**

**SUBJECT:** Medi-Cal: eligibility.

**SUMMARY:** Implements the expansion of federal Medicaid coverage in California (Medicaid is known as Medi-Cal in California) to low-income adults with incomes between 0 and 138 percent of the federal poverty level (FPL), establishes the Medi-Cal benefit package for this expansion population, and requires the existing Medi-Cal program to cover the essential health benefits (EHB) contained in the Patient Protection and Affordable Care Act (ACA). Implements a number of the Medicaid ACA provisions to simplify the eligibility, enrollment and renewal processes for Medi-Cal.

**Background:**
On March 23, 2010, President Obama signed the ACA into law (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). The ACA greatly expands health insurance coverage in California. Beginning in 2014, millions of low- and middle-income Californians will gain access to coverage under the expansion of Medi-Cal through easier enrollment requirements established for Medi-Cal, and through premium and cost-sharing subsidies offered through the California Health Benefit Exchange (the Exchange, which is now known as Covered California). As a result of the coverage expansions under the ACA, between 89 and 91 percent of non-elderly Californians are predicted to have health coverage under the ACA, and the number of uninsured is projected to decrease by between 1.8 and 2.7 million by 2019.

The ACA establishes new requirements for California's Medi-Cal program, including:
- Requiring Medicaid coverage of adults under age 65 who are not currently eligible with incomes up to 138 percent of the FPL (at or below $15,856 in 2013 for an individual);
- Requiring primary care rates to be equal to Medicare rates for 2013 and 2014;
- Extending Medi-Cal coverage to former foster youth up to age 26;
- Allowing individuals to apply for Medi-Cal in person, via phone, by mail, and through the internet or facsimile;
- Eliminating the asset test for certain groups of applicants to Medi-Cal; and,
- Establishing a new methodology for counting income in Medi-Cal, known as modified adjusted gross income (MAGI).

In addition to these ACA requirements, California has a number of policy options in implementing the Medicaid provisions. Options include whether to implement the Medi-Cal expansion (the Supreme Court ruling in *National Federation of Independent Business v. Sebelius* in June 2012 effectively allowed states to opt-out of the expansion), the type of benefits and services the expansion population will receive in Medi-Cal, and whether to adopt options

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contained in the ACA to make it easier for individuals to enroll in coverage and remain enrolled in coverage through the use electronic verification of eligibility-related information.

This analysis is broken down by each major policy area affected by this bill, describes existing federal law and state law, the proposed change to state law, gives background on existing law (if necessary), and provides the rationale for the proposed changes.

**Medi-Cal Expansion to Low-Income Adults**

Under existing federal law, prior to the enactment of the ACA, adults were generally not eligible for Medi-Cal coverage unless they met categorical eligibility requirements, such as being low-income and having minor children living at home, having a disability, being over the age of 65, or being pregnant. Currently, Medicaid requires financial need and a categorical relationship (family with children, aged, persons with disability). For example, adults who are not disabled, pregnant or who do not have minor children are not categorically eligible for Medi-Cal. The 2014 Medicaid expansion's largest enrollment impact will be from the expansion to non-disabled childless adults with incomes at or below 138 percent of the FPL (for a single adult, 138 percent of the FPL is $1,321 per month or $15,856 per year in 2013).

Counties draw down federal Medicaid matching funds to cover low-income adults under California's "Bridge to Reform" Section 1115 Medicaid waiver as a transition to implementation of the ACA Medicaid expansion through the Low Income Health Program (LIHP). Over 500,000 individuals are covered under the LIHPs, but not all counties have LIHPs (three counties have elected not to implement a LIHP [Fresno, Merced and San Luis Obispo]. The benefits in the LIHPs are more limited than in Medi-Cal, and eligibility varies county by county. For example, eligibility for San Francisco's LIHP is 25 percent of the FPL and Santa Clara is 75 percent of the FPL. Coverage under the LIHPs ends December 31, 2013. Statute establishing the LIHP requires the state, on and after January 1, 2014, to implement comprehensive health care reform for the populations targeted by the LIHP in compliance with the federal ACA and subsequent amendments.

Under the ACA, starting January 1, 2014, Medi-Cal will expand coverage to most adults who are at or below 138 percent of the FPL. This coverage expansion applies to non-elderly, non-pregnant adults under the age of 65. The Supreme Court ruling in June 2012 effectively allowed states to opt-out of the expansion by prohibiting the federal government from withholding federal Medicaid funds for a state's entire Medicaid program if the state failed to implement the expansion.

SB X1 1 would implement the Medicaid expansion in California. In addition, SB X1 1 would require that individuals who qualify for the Medicaid expansion who are currently enrolled in a LIHP be transitioned to the Medi-Cal program in accordance with the transition plan as approved by the federal Centers for Medicare and Medicaid Services (CMS). SB X1 1 would require LIHP enrollees be:

- Notified which Medi-Cal health plan or plans contain his or her existing medical home provider.
- Notified that he or she can select a health plan that contains his or her existing medical home provider.
- Provided the opportunity to choose a different health plan if there is more than one plan available in the county where he or she resides.

- Informed that if he or she does not affirmatively choose a plan or there is only one plan in the county where he or she resides, he or she shall be enrolled into the Medi-Cal managed care plan that contains his or her LIHP medical home provider, if the medical home provider contracts with a Medi-Cal managed care plan.

In order to ensure that no persons lose health care coverage in the course of the transition, notices of the January 1, 2014, change must be sent to LIHP enrollees upon their LIHP redetermination in 2013 and again at least 90 days prior to the transition.

**Medi-Cal benefits for the current population and expansion population**

Under existing federal law (since 2006), state Medicaid programs have had the option to provide certain groups of enrollees with an alternative benefit package known as "benchmark" or "benchmark-equivalent" coverage. The four benchmarks are:
(1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program;
(2) State employee coverage that is offered and generally available to state employees;
(3) The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state; and
(4) Secretary-approved coverage, which can include the Medicaid state plan benefit package offered in that state.

"Benchmark-equivalent" means that the benefits include certain specified services, and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages. California has not implemented this federal option. The ACA requires states to select a benefit package for the Medi-Cal expansion population using "benchmark" or "benchmark-equivalent" coverage.

The ACA requires any Medicaid benchmark benefit package to additionally provide coverage for the EHB. The ten EHB are ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. CMS indicates a state is not required to select the same EHB benchmark reference plan it selects for the individual and small group market (California designated the Kaiser Small Group product as the state's EHB benchmark plan in legislation last session), and it could have more than one EHB benchmark reference plan for Medicaid.

Under the ACA, the Medicaid benefits provided to the expansion population of adults must be consistent with the federal law benchmark authority. If the EHB benchmark reference plan selected for Medicaid were to lack coverage within one or more of the ten required categories of benefits, it would need to be supplemented to ensure that it provides coverage in each of the ten EHB categories. This would be in addition to any other requirements for benchmark or benchmark-equivalent plans, including federal mental parity (known as the Mental Health Parity and Addition Equity Act) compliance.

SB X1 1 would require the Department of Health Care Services (DHCS) to seek federal approval to establish a benchmark benefit package that includes the same benefits, services, and coverage that are provided to all other full-scope Medi-Cal enrollees. In addition, these benefits would be

supplemented by any benefits, services, and coverage included in the EHB package adopted by the state and approved by the federal Secretary of the Department of Health and Human Services (DHHS). In addition, SB X1 1 would require the existing Medi-Cal benefit package for the non-expansion population to include any benefits, services, and coverage not otherwise described in existing law that are included in the approved EHB package.

**Medi-Cal coverage for former foster youth until age 26**

Federal regulations require states to provide Medicaid to children for whom adoption assistance or foster care maintenance payments are made. In addition, California has adopted the federal option that allows states to provide Medicaid coverage for former foster children between the ages of 18 and 21. The state does not require an income, asset test or share-of-cost for former foster youth. In 2010, there were slightly more than 7,000 former foster youth ages 18 through 20 enrolled in Medi-Cal.

The ACA requires states cover former foster care children who:

- Are under 26 years of age;
- Are not eligible or enrolled under existing Medicaid mandatory eligibility groups (or who are described in any of the existing Medicaid mandatory eligibility groups but have income that exceeds the upper income eligibility limit);
- Were in foster care under the responsibility of the state at 18 years of age (or such higher age as the state has elected); and
- Were enrolled in the Medicaid state plan or under a waiver while in foster care.

The ACA also allows states to make "presumptive eligibility" determinations for these individuals. Medicaid services rendered to individuals in this new mandatory eligibility group will be matched at the state's regular federal funds matching rate, which in California is usually 50 percent federal funds and 50 percent state funds.

This provision takes effect January 1, 2014, and mirrors a similar provision in the ACA that allows dependents to stay on their parents' private insurance coverage until age 26.

SB X1 1 would require, to the extent federal financial participation (FFP) is available, DHCS to extend Medi-Cal benefits to a foster care youth until age 26. A foster care youth would be deemed eligible for the benefits, and would be enrolled to receive these benefits until his or her 26$^{th}$ birthday without any interruption in coverage and without requiring a new application so long as he/she was in foster care on his/her 18$^{th}$ birthday. These changes are required by the ACA. SB X1 1 does not implement the presumptive eligibility option.

In addition to the federally required changes, DHCS would also be required by SB X1 1 to identify and track all former independent foster care youth who lost Medi-Cal coverage as a result of turning age 21 in the 2013 calendar year. DHCS would be required to develop and implement a simplified redetermination form for these youth. A former foster youth qualifying for the benefits would be required to fill out and return this form only if information previously reported to DHCS is no longer accurate, and failure to return the form alone would not constitute a basis for termination of Medi-Cal. If the form is returned as undeliverable and the county is otherwise unable to establish contact, the former foster youth would remain eligible for fee-for-service Medi-Cal until such time as contact is reestablished or ineligibility is established, to the extent FFP is available. These changes would take effect January 1, 2014.

The requirement in SB X1 1 that DHCS track independent foster care adolescent who lost Medi-Cal coverage as a result of turning age 21 in the 2013 calendar year is because these individuals will lose Medi-Cal coverage upon the date of their 21st birthday, only to be eligible again effective January 1, 2014 under the ACA. The provisions regarding the return of undelivered forms ensure that former foster youth are not disenrolled because they have moved and their mail is returned as undeliverable. Former foster youth retain their right to Medi-Cal coverage if they move within the state, obtain a job and have an increase in income or obtain health insurance (in which case Medi-Cal coverage would be the secondary payor), so removing them from coverage to which they are entitled does not make sense. This provision would also ensure these individuals retain access to health care services and decrease the amount of "churning," which occurs when a beneficiary loses coverage and must reapply for coverage. If the redetermination form is returned as undeliverable and the county is unable to establish contact with the individual, SB X1 1 would shift the former foster youth's Medi-Cal coverage to fee-for-service (if he or she is in Medi-Cal managed care) until contact is re-established or the person is found ineligible so the state is not making monthly capitation payments to Medi-Cal managed care plans for individuals who have moved out of state or are deceased.

**Implementation of ACA option for attestation of application-related information**

Existing state law required DHCS, by July 1, 2007, to implement a process that allows applicants and beneficiaries of certain Medi-Cal programs to self-certify the amount and nature of assets and income without the need to submit documentation. This process is required to apply to applicants and beneficiaries in the 1931(b) program, the FPL programs for infants, children and pregnant women, the Medically-Indigent and Medically-Needy Programs for children and families, and other similar programs designated by DHCS. This process was to be implemented in two phases. However, these provisions have not been implemented.

Federal regulations implementing the ACA allow the agency determining eligibility (counties in California) to accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation or attestation by an adult who is in the applicant's household) without requiring further information (including documentation). Self-attestation is not permitted for citizenship status and immigration. Federal regulations require the agency to accept self-attestation for pregnancy unless the state has information that is not reasonably compatible with the attestation. The county is authorized to verify state residency, date of birth, and household size and composition.

To determine financial eligibility, federal regulations require the county to request specified information from other agencies in the state, other states, and federal programs to the extent such information is useful in verifying the financial eligibility of an individual. In addition, federal ACA regulations require the Secretary of DHHS to establish an electronic service through which states can verify information with or obtain information from federal agencies and other data sources (referred to as the "federal data hub"). Counties must promptly evaluate information received or obtained to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled. If information provided by an individual is reasonably compatible with information obtained by the county, it must determine or renew eligibility based on that information. CMS guidance indicates that, if a state accepts self-attestation of income, it must conduct post-enrollment verification with the electronic data sources it determines useful.

Current state law authorizes state health subsidy programs to accept self-attestation with respect to all information needed to determine eligibility, to the extent permitted by law state and federal law.

SB X1 1 would require state health subsidy programs (Medi-Cal, coverage through Covered California and the Basic Health Program, if enacted), to accept an individual's attestation, without further documentation, for age, date of birth, family size, household income, state residency, pregnancy, and any other applicable eligibility criteria for which attestation is permitted by federal law.

The purpose of this provision is to implement the ACA option, to reduce program administrative costs, and to move the state toward electronic verification and away from the existing burdensome paper-based application process. The preamble of federal regulations indicates the purpose of the proposed federal changes was to make verification processes more efficient, modern, and coordinated by relying on trusted third-party electronic data sources and shifting certain verification responsibilities to the federal government, rather than using paperwork submitted by Medi-Cal applicants and beneficiaries.

**Prohibition on asset test for MAGI individuals, required 5 percent income disregard, and equivalent income standard**

Existing state law requires each Medi-Cal applicant who is not a recipient of aid under the California Work Opportunity and Responsibility to Kids Act (CalWORKS) or Supplemental Security Income/State Supplementary Payment (SSI/SSP) to file an affirmation setting forth such facts about his or her annual income and other resources and qualifications for eligibility, as may be required by DHCS.

Prior to the ACA, federal rules allowed income and asset eligibility standards to vary across states, and different standards to apply to different groups within states. For example, children and pregnant women in California are eligible for Medi-Cal without an asset test, while families under the 1931(b) coverage category have an asset test. Assets include cash, savings, stocks, bonds, mutual funds, property, and life insurance policies with a face value of less than $1,500. Certain property is exempt, including a home, clothing, and the first $4,650 value of a car. Property limits vary with family size. For a family of two persons, the property limit is $3,000.

Effective January 1, 2014, the ACA requires states to change the way they calculate income for purposes of determining Medi-Cal eligibility. Under the ACA, state income disregards and asset or resource tests would no longer apply when calculating income eligibility (except for specified groups, such as seniors and individuals eligible for Medicaid on a basis that does not require determination of income by the Medicaid state agency). In addition, the ACA prohibits the use of an asset or resource test, except for:

- Individuals eligible for Medicaid on a basis that does not require a determination of income by the Medicaid state agency (for example, foster care children, or individuals receiving SSI);
- Individuals who have attained age 65;
- Individuals who qualify for Medicaid on the basis of being blind or disabled regardless of whether the individual is eligible for SSI;
- Medically needy individuals;
- Individuals dually eligible for Medicare and Medicaid; and

- Individuals whose eligibility is being determined for purposes of receiving nursing facility services, a level of care in any institution equivalent to a nursing facility, home or community-based services furnished under a Medicaid waiver or state plan amendment.

Instead, the income eligibility for an individual or a family would be measured based on MAGI. MAGI is defined as the Internal Revenue Code's Adjusted Gross Income, which allows a number of income deductions, including trade and business deductions, losses from the sale of property, and alimony payments. MAGI is increased by tax-exempt interest and income earned by U.S. citizens or residents living abroad.

SB X1 1 would conform state law to the ACA by prohibiting the use of an asset or resource test for individuals whose financial eligibility for Medi-Cal is determined based on MAGI. In addition, SB X1 1 would implement the ACA requirement that a five percent income disregard applies to individuals whose income eligibility is determined based on MAGI.

Finally, SB X1 1 would require DHCS, effective January 1, 2014, to implement an equivalent income level for each eligibility group whose income level will be converted to MAGI. The equivalent income level shall not be less than the dollar amount of all income exemptions, exclusions, deductions, and disregards in effect on March 23, 2010, plus the existing income level expressed as a percent of the federal poverty level for each eligibility group so as to ensure that the use of MAGI income methodology does not result in populations, who would have been eligible for either the Medi-Cal Program or the Healthy Families Program, losing coverage. The state is awaiting further guidance from the federal government on implementation of the equivalent income level.

**Changes to Pregnancy-Related Coverage in California**

Access for Infants and Mothers Program

State law establishes the Access for Infants and Mothers (AIM) Program, which provides prenatal care, labor and delivery and coverage for pregnant women with family income between 200 percent and 300 percent of FPL, and for children less than 2 years of age who were born under AIM. AIM coverage continues for 60 days postpartum. If the 60$^{th}$ day falls in the middle of the month, coverage terminates as of that date.

Federal regulations for Exchanges (Covered California) require individuals enrolling between the 1$^{st}$ and the 15$^{th}$ of a month to have coverage the first day of the following month. For individuals enrolling between the 16$^{th}$ and the last day of the month, the Exchange must ensure a coverage effective date on the first day of the second following month.

SB X1 1 would require, at a minimum, AIM coverage to be provided to pregnant women during pregnancy, and until the end of the month in which the 60$^{th}$ day thereafter occurs. This change would take effect January 1, 2014.

The purpose of this change is so that coverage does not end in the middle of the month, to avoid a gap in coverage between when AIM coverage ends and coverage through the Exchange begins, and to conform to the existing Medi-Cal requirement to provide coverage until the end of the month in which the 60$^{th}$ day occurs.

Full scope coverage for pregnant women in Medi-Cal

State law requires Medi-Cal to cover pregnant women without a share of cost with incomes below 200 percent of the FPL. However, the type of coverage a woman receives (full scope Medi-Cal coverage versus Medi-Cal coverage for pregnancy-only services) depends upon her income, immigration status, assets, and whether she meets other criteria (a pregnant woman can only receive full scope coverage if she has "linkage" to Medi-Cal because she has a "deprived" child in the home, is in her third trimester, or is disabled or blind). For example, a low-income pregnant woman in her first or second trimester with income below 100 percent of the FPL does not qualify for full-scope Medi-Cal unless she is otherwise linked to Medi-Cal (such as being on CalWORKS or disabled) until she reaches her third trimester.

If a low-income pregnant woman is not eligible for full-scope benefits, she is eligible for pregnancy-only services without a share of cost if her income is at or below 200 percent of the FPL. There is no asset test for pregnancy only coverage. Pregnancy-only coverage covers prenatal care, labor and delivery, and care through the end of the month in which the 60$^{th}$ post-partum day occurs.

Draft federal regulations released in January 2013 revise the Medicaid exemption for pregnancy-related services so that all services provided to pregnant women must be considered pregnancy-related unless specifically identified in the state plan as not pregnancy-related. In addition, the most recent proposed Internal Revenue Service regulations that define minimum essential coverage for purposes of meeting the requirement that individual maintain such coverage (known as the "individual mandate") states that pregnancy-related services under Medicaid do not provide minimum essential coverage.

SB X1 1 would require that pregnant women enrolled in Medi-Cal be provided with all medically necessary services, and not just pregnancy-only coverage, unless federal approval is granted to provide fewer benefits during pregnancy. SB X1 1 would define "pregnancy-related services" to mean, at a minimum, all services required under the Medi-Cal program unless federal approval is granted to provide fewer benefits during pregnancy. This requirement would take effect January 1, 2014.

The purpose of providing full scope coverage to pregnant women is to help prevent premature delivery and low birth weight infants, and to promote women's overall health, well-being, and financial security and that of their families.

**Repeal of semi-annual status reports**

Existing state law requires adult Medi-Cal beneficiaries to file a semi-annual status report in order to remain eligible for Medi-Cal. Existing state law also requires information about the semi-annual status report to be included in a notice used by counties for Medi-Cal beneficiaries.

Regulations implementing the Medicaid ACA changes require individuals' whose income is determined using MAGI to be renewed once every 12 months but not more frequently than once every 12 months, thus prohibiting the semi-annual status report requirement.

SB X1 1 would conform state law to the federal regulation by repealing the semi-annual status report requirement.

**Authorized representative to assist in application and renewal process**

Regulations implementing the ACA Medicaid changes require agencies to allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility.

DHCS indicates it does not have statute or regulation that defines authorized representatives.

SB X1 1 would require a person who wishes to apply for a state health subsidy program to be allowed to file an application on his or her own behalf or on behalf of his or her family. The individual also would have the right to be accompanied, assisted, and represented in the application and renewal process by an individual or organization of his or her choosing. If the individual for any reason is unable to apply or renew on his or her own behalf, any of the following persons may file the application for the applicant:

- The individual's guardian, conservator, or executor;
- A public agency representative; or
- The individual's legal counsel, relative, friend, or other spokesperson of his or her choice.

SB X1 1 would give a person, who wishes to challenge a decision concerning his or her eligibility for or receipt of benefits from a state health subsidy program, the right to represent himself or herself or use legal counsel, a relative, a friend, or other spokesperson of his or her choice.

The purpose of this provision of the bill is to meet the ACA requirement, and to address an issue raised during the Medi-Cal managed care stakeholder workgroup process regarding individuals who are authorized representatives in the federal Social Security System are not recognized as authorized representatives by the state Medi-Cal computer system (known as MEDS).

**Repeal of deprivation requirement**

Under existing state law, the Medi-Cal 1931(b) program covers children up through age 18 (and up to age 19 if they are expected to graduate) and parents and caretaker relatives who are "deprived" of full parental support. Deprivation means at least one parent in the family must be absent, deceased or disabled, or the principal wage earner must be unemployed or underemployed.

The ACA allows states to eliminate the deprivation requirement.

SB X1 1 adopts the ACA option to repeal the deprivation requirement.

The purpose of eliminating the deprivation requirement is there is no longer a need for an administratively burdensome and outdated welfare-based rule when individuals are subject to an individual mandate and are eligible for coverage.

**Requirements prior to terminating Medi-Cal coverage**

Existing state law establishes requirements for counties prior to terminating eligibility for Medi-Cal under legislation known as SB 87 (Escutia), Chapter 1088, Statutes of 2000. Under SB 87, counties must 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. This includes Medi-Cal, CalWORKS, and CalFresh case files of the beneficiary or any of his or her immediate family members.

Federal regulations require the county to make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account, or other more current information available to the county. If the county is able to renew eligibility based on such information, the county must notify the individual of the eligibility determination, basis, and that the individual must inform the county, through any of the modes permitted for submission of applications (by telephone, in person, mail, or through other commonly available electronic means) if any of the information contained in such notice is inaccurate. The individual is not required to sign and return such notice if all information is accurate. If the county cannot renew eligibility, the county must provide the individual with a renewal form containing specified information.

SB X1 1 would eliminate the provision that limits the requirement that counties "make every reasonable effort" to gather information, thereby requiring counties to gather the information. It would also require counties to check federal and state databases to verify financial and non-financial information.

SB X1 1 would require the county, if it is able to renew eligibility based on information in the databases, to notify the individual of the eligibility determination and basis, and that the individual is required to inform the county if any information contained in the notice is inaccurate. Under SB X1 1, the individual would not be required to sign and return the notice if all information provided on the notice is accurate so as to conform to federal regulations. Counties would be required to make all reasonable efforts not to send multiple notices during the same time period about eligibility, and the notice of eligibility renewal must contain other related information, such as if the individual is in a new Medi-Cal program.

Under existing state law, if a county cannot obtain information necessary to redetermine eligibility, counties have to attempt to reach the beneficiary by telephone. SB X1 1 would also require the county to attempt to reach the beneficiary through other commonly available electronic means (for example, email or text) in counties where such electronic means are available.

Under existing state law, if a county's efforts to obtain the information necessary to redetermine eligibility have failed, the county is required to send to the beneficiary a form which highlights the information needed to complete the eligibility determination. SB X1 1 would repeal this requirement and instead require the county to send a form containing information available to the county needed to renew eligibility, and would require the form to advise the individual to provide any necessary information to the county via internet, telephone, mail, in person or through other commonly available electronic means, and to sign the renewal form. This bill would prohibit a county from requesting information from non-applicants necessary to make an eligibility determination.

Under existing state law, if a beneficiary submits an incomplete form, counties must attempt to contact the beneficiary by telephone.

SB X1 1 would require counties to attempt to contact the beneficiary in writing and other commonly available electronic means in counties where such electronic communication is available.

Federal regulations implementing the Medicaid ACA-related changes extend this 30-day timeframe. These regulations require, for individuals whose income is determined based on MAGI, annual eligibility redeterminations to be reconsidered if an individual whose eligibility has been terminated for failure to submit the renewal form or necessary information submits the required information within 90 days, or a longer period elected by the state, without requiring a new application.

Under existing state law, if a Medi-Cal beneficiary is terminated from coverage, but that former beneficiary submits a completed form within 30 days of termination, the county is required to determine eligibility as though the form was submitted in a timely manner. If the beneficiary is found eligible, existing law requires the termination to be rescinded.

SB X1 1 would conform state law to the federal regulation by codifying the 90-day federal requirement, but would not extend it beyond 90 days.

SB X1 1 would also require the county, if it has enough information available to it to renew eligibility with respect to all eligibility criteria, to begin a new 12-month eligibility period. For individuals determined ineligible for Medi-Cal, SB X1 1 would require the county to determine eligibility for other state health subsidy programs, and comply with specified procedures in existing law. SB X1 1 would also require any renewal form or notice to accessible to persons who are limited English proficient and persons with disabilities consistent with all federal and state requirements.

**Blindness and disability**

Federal regulations allow counties determining eligibility to consider blindness as continuing until the reviewing physician determines that a beneficiary's vision has improved beyond the definition of blindness contained in the state's Medicaid State Plan. In addition, the Medicaid ACA-related changes allow the county to consider disability as continuing until the review team determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

SB X1 1 would adopt the two federal options outlined above. DHCS indicates this provision adopts its current policy.

**Redetermination of Medi-Cal eligibility**

Existing state law requires Medi-Cal redetermination to be filed annually. Existing law permits redetermination to be required at other times in accordance with general standards established by DHCS.

Federal regulations implementing the Medicaid ACA changes prohibit an individual whose income is determined using the MAGI methodology to be renewed once every 12 months but not more frequently than once every 12 months, thus prohibiting the semi-annual status report requirement.

SB X1 1 eliminates the semi-annual status report requirement to conform to federal requirements.

**Implementation of Income Option**

Federal regulations implementing the ACA require, for applicants and new enrollees, financial

eligibility to be based on current monthly household income and family size. For current beneficiaries, individuals who have been determined financially eligible for Medicaid using the MAGI-based methods, a state may elect to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

SB X1 1 would require DHCS to adopt procedures to take into account projected future changes in income and family size, for individuals whose Medi-Cal income eligibility is determined using MAGI-based methods, in order to grant or maintain eligibility for those individuals who may be ineligible or become ineligible if only the current monthly income and family size are considered.

For current beneficiaries, SB X1 1 would require DHCS to base financial eligibility on projected annual household income for the remainder of the current calendar year if the current monthly income would render the beneficiary ineligible due to fluctuating income. For applicants, DHCS would be required to base an initial determination of eligibility on the projected annual household income and family size for the upcoming year if considering the current monthly income and family size in isolation would render an applicant ineligible.

SB X1 1 would require DHCS to implement a reasonable method to account for a reasonably predictable decrease in income and increase in family size, as evidenced by a history of predictable fluctuations in income or other clear indicia of a future decrease in income and increase in family size. SB X1 1 would prohibit DHCS from assuming potential future increases in income or decreases in family size to make an applicant or beneficiary ineligible in the current month.

The MC 210 application for Medi-Cal instructs individuals to list how much income they receive. The MC 210 instructs individuals, who know that their family's income will fluctuate in the next few months, to explain this on a separate sheet of paper. The provision in allowing the use of projected annual income SB X1 1 provides individuals the option to still enroll in Medi-Cal by using their annual income if they have knowledge their annual income is likely to be lower than their current income in the month they apply for Medi-Cal.

**FISCAL EFFECT:** This bill has not been analyzed by a fiscal committee.

**COMMENTS:**

1. **Author's statement.** According to the author, SB X1 1 expands Medi-Cal eligibility up to 138 percent of the FPL to adults who are not currently Medi-Cal eligible. This expansion is estimated to result in more than 1.4 million Californians being newly eligible for Medi-Cal, of whom between 750,000 and 910,000 are expected to be enrolled at any point in time by 2019. There are multiple policy and fiscal reasons for implementing the expansion, including:
   - Reducing the number of uninsured in California;
   - Improving the health status of the newly eligible Medi-Cal recipients;
   - Providing significantly enhanced federal funding for California;
   - Providing enhanced funding for safety-net health care providers to serve the 3.1 to 4 million remaining uninsured;
   - Reducing health care providers' uncompensated care costs; and

- Preventing lower income individuals from being without access to affordable health care coverage when higher income individuals have access to tax credits that reduce premium and cost-sharing costs in Covered California.

The policy and fiscal reasons for using the Medi-Cal benefit package for the expansion population and the current eligible population are to:

- Provide a consistent benefit package across both existing and expansion Medi-Cal population;
- Make the program easier to administer for health plans, providers, counties and the state;
- Eliminate the incentive to shift from benchmark coverage to the existing Medi-Cal benefit package for enhanced benefits not available to expansion population at higher state cost;
- Provide an economic stimulus benefit from enhanced federal funding from a broader benefit package; and
- Avoid having to oversee costly and administratively difficult exemptions from the benchmark benefit packages.

Finally, SB X1 1 implements a number of the Medicaid ACA provisions to simplify the eligibility, enrollment, and renewal processes for Medi-Cal coverage.

2. **Should the state adopt the Medicaid expansion?** The policy and fiscal reasons for implementing the federal Medicaid expansion include:

- The Medicaid expansion would reduce the number of uninsured in California. According to a California HealthCare Foundation's December 2012 publication on California's uninsured, California had the largest total number of people under 65 years of age without health insurance - 7.1 million - of any state in the nation. Implementing the Medi-Cal expansion would allow hundreds of thousands of currently uninsured adults to obtain medically needed services through the Medi-Cal program.

- Medicaid reduces mortality, improves access to health care, improves financial security and improves self-reported health status. According to data from UC Berkeley-UCLA CalSIM model, Version 1.8, 31 to 36 percent of individuals projected to enroll in Medi-Cal who are in the expansion population rate their health status as "fair" or "poor." A UCLA Center for Health Policy Research 2012 Fact Sheet reported that 68.5 percent of uninsured adults with mental health needs, who were between the ages of 18 to 65, received no treatment. The UCLA Fact Sheet indicated that 254,000 individuals or 47 percent of the 541,000 uninsured individuals with mental health needs would be eligible for the Medi-Cal expansion.

  A study published in the September 2012 edition of the *New England Journal of Medicine* (NEJM) compared three states that have substantially expanded adult Medicaid eligibility since the year 2000 (New York, Maine, and Arizona) with neighboring states without expansions. The study reported that Medicaid expansions were associated with a significant reduction in mortality, decreased rates of uninsurance, decreased rates of delayed care due to costs, and increased rates of self-reported health status of "excellent" or "very good." The NEJM study concluded that "[S]tate Medicaid expansions to cover low-income adults were significantly associated with reduced mortality as well as improved coverage, access to care, and self-reported health."

  Another study published in the August 2011 edition of the NEJM examined Oregon's use

of a lottery in 2008 to allocate a limited number of Medicaid spots for low-income adults (19 to 64 years of age) to people on a waiting list for Medicaid. The study found people with Medicaid had improved access to medically needed health care, including being 70 percent more likely to have a regular place of care and 55 percent more likely to report having a usual doctor. Medicaid coverage also increased the use of preventive care such as mammograms (by 60 percent) and cholesterol monitoring (by 20 percent). Medicaid coverage also provided improved financial protection, reducing by 40 percent the probability that people report having to borrow money or skip payment on other bills because of medical expenses and decreasing by 25 percent the probability that they will have unpaid medical bills that are sent to a collection agency. Finally, the study found Medicaid coverage improves self-reported health as compared with being uninsured. Medicaid enrollees were 25 percent more likely to indicate they are in good, very good or excellent health, and 25 percent less likely to screen positive for depression.

- The Medicaid expansion provides significantly enhanced federal funding for California. Under the ACA, the cost of Medicaid benefits for the expansion population are 100 percent federally funded for the first three years (2014-2016), 95 percent federally funded in 2017, 94 percent federally funded in 2018, 93 percent federally funded in 2019 and 90 percent federally funded in 2020 and thereafter. States will be able to offer a significant benefit to some of their residents while bearing only a small fraction of the costs. The UC Berkeley Labor Institute and the UCLA Center for Health Policy Research estimate the Medi-Cal expansion and enrollment growth among those already eligible is predicted to bring between $2.1 and $3.5 billion in new federal Medi-Cal dollars to California in 2014, growing to between $3.4 and $4.5 billion in 2019.

- Increased funding for health care safety net. The Medi-Cal expansion will provide more funding for safety net health care providers that currently care for Medi-Cal beneficiaries, the uninsured and low-income populations, and will reduce health care providers' uncompensated care costs. While the ACA will make a significant reduction in the number of uninsured in California, an estimated 3.1 to 4 million individuals will remain uninsured in 2019 following implementation of the ACA. These "residual uninsured" will continue to access safety net providers for their care, and the Medi-Cal expansion will assist these providers by providing additional revenue through Medi-Cal and by reducing the amount of uncompensated care from expansion-eligible individuals who were previously uninsured.

- Failure to expand Medi-Cal is inequitable to the lowest-income adults. The ACA provides refundable and advanceable tax credits that reduce premium costs for individuals with incomes between 100 and 400 percent of the FPL, and legal immigrants who are ineligible for Medicaid with incomes below 100 percent of the FPL up to 400 percent of the FPL who purchase coverage through Covered California. In addition, individuals with incomes up to 250 percent of the FPL purchasing coverage in the silver tier through Covered California and legal immigrants below 100 percent of FPL who are ineligible for Medicaid are eligible for reduced cost-sharing (e.g., coverage with lower deductibles and co-payments).

  If California fails to enact the Medicaid expansion, premium and cost-sharing subsidies will be provided to Californians with incomes between 100 and 400 percent of the FPL

but California adults who are not immigrants without children with incomes below 100 percent of the FPL will not be eligible for any public program or premium subsidies.

- States costs of covering increased enrollment of people who are already Medi-Cal eligible will occur whether or not the state expands Medi-Cal. According to the UC Labor Institute and the UCLA Center for Health Policy Research, about 2.5 million Californians are already eligible for Medi-Cal but not enrolled. Between 240,000 and 510,000 of these eligible but not yet enrolled Californians are expected to be enrolled in Medi-Cal coverage at any point in time by 2019.

  A state will have to incur certain costs under the ACA even if it does not expand Medicaid. The ACA's requirement to purchase insurance (known as the individual mandate), its required simplification of Medicaid eligibility procedures, and the significant outreach and education that will be aimed at encouraging individuals to apply for subsidized coverage in the Exchanges will increase Medicaid participation among individuals who are currently eligible but are not enrolled, even if a state rejects the Medicaid expansion. A state will incur some additional costs for covering some of these individuals regardless of whether it expands Medicaid, and such costs cannot be attributed to the Medicaid expansion.

- Failure to provide Medicaid expansion is projected to increase private insurance rates. According to a Decision Brief by the American Academy of Actuaries, states' decisions to expand Medicaid eligibility will affect not only access to coverage and costs to the federal government and the states, but also the premiums for private insurance coverage. For example, the ACA provides premium subsidies to individuals purchasing coverage in the Exchange if they have income between 100 percent and 400 percent of FPL and who are not eligible for Medicaid or are not offered employer-sponsored coverage that meets minimum value and affordability requirements. Individuals below 100 percent of FPL who are not eligible for Medicaid are not eligible for subsidies in the Exchange.

  If a state opts not to extend Medicaid eligibility to 138 percent of FPL, then individuals 100 percent to 138 percent of FPL who otherwise would have been eligible for Medicaid will have access to premium subsidies in the Exchange. This population can be expected to have higher health care needs than higher-income Exchange enrollees. The Congressional Budget Office (CBO) estimates that, due to the likely higher health spending among lower-income enrollees, average individual market premiums will be 2 percent higher than projections made under the assumption that all states expand Medicaid to 138 percent of FPL. This CBO estimate reflects the increase in average premiums overall, including not only states that opt out of the Medicaid expansion but also those that expand Medicaid. Therefore, premium increases would be even higher among those states that do not expand Medicaid. Premium increases would be borne by nonsubsidized purchasers and by the federal government for subsidized enrollees.

- States cannot enact partial expansions and receive enhanced federal funding. In December 2012, the federal CMS indicated that states cannot enact partial Medicaid expansions and still receive the enhanced federal funding available under the ACA. Congress directed that the enhanced Medicaid matching rate be used to expand coverage to 138 percent of the FPL, and the law does not provide for a phased-in or partial expansion. As such, CMS indicated it will not consider partial expansions for populations

eligible for the 100 percent matching rate in 2014 through 2016. CMS indicates that if a state that declines to expand coverage to 138 percent of FPL, and would like to propose a demonstration project that includes a partial expansion, CMS would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate (which in California is usually 50 percent state funds, 50 percent federal funds). In 2017, when the 100 percent federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstration projects. This demonstration authority offers states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. CMS indicated it will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.

- Hospitals in states that do not enact Medicaid expansion will still receive reduced "disproportionate share" hospital payments. Federal disproportionate share hospital (DSH) payments provide additional federal funds to those hospitals that serve a significantly disproportionate number of low-income and Medi-Cal patients. The annual DSH allotment is calculated by federal law.

  Beginning in federal fiscal year 2014, the ACA dramatically decreases the amount of funding that will be provided under both DSH programs, based on the premise that the ACA coverage expansions will result in fewer individuals receiving uncompensated care. Under the ACA, the federal Secretary of DHHS is required to develop a methodology that will reduce the DSH payments by $14.1 billion during the period 2014 to 2019, pursuant to a schedule set out in the ACA. These reductions increase over time, and by 2019 represent an approximate 50 percent reduction over baseline projections. These reductions will occur even if states do not expand Medicaid.

  California's DSH allotment for 2013-14 is estimated to be $1.132 billion. The DHCS' 2013-14 budget assumes a reduction of 4.4 percent will be applied in 2013-14. This will result in reductions in DSH payments to private hospitals (known as "virtual DSH") of $31.9 million ($15.9 million state funds/$15.9 million federal funds) and $69.4 million to public DSH hospitals ($24 million non-federal funds/$45.4 million federal funds).

  If California does not expand Medi-Cal up to 138 percent of FPL, the need for funding to address uncompensated care will continue, while the amount of DSH funds that were previously used to subsidize some of the costs of that care will decrease substantially. This may lead some hospitals to provide less uncompensated care or pursue higher payments from health plans or other third-party payors to offset additional uncompensated care costs.

3. **Arguments for Medi-Cal having the same benefit package.** The policy and fiscal reasons for using the Medi-Cal benefit package for the expansion population and the EHB for the currently eligible population are as follows:

   - Consistent benefit package across both existing and expansion Medi-Cal population. Requiring the expansion population and the current Medi-Cal population to receive the same benefit package will ensure coverage is available and affordable for this population

which has virtually no ability to afford private individual coverage at these income levels. Aligning benefits received by the existing Medi-Cal population will provide a consistent benefit package to both the currently eligible and the expansion population, and will ensure continuity of care by eliminating the need to shift benefit packages if Medi-Cal beneficiaries move into a different eligibility category because of a change in eligibility.

- Ease of administration for providers and state. One uniform benefit package for both the newly eligible expansion population and current Medi-Cal program will be administratively simpler for the state, counties, health plans, and health care providers to administer.

- Eliminates incentive to shift from benchmark coverage to the existing Medi-Cal benefit package for enhanced benefits not available to expansion population at higher state cost. Aligning benefits would simplify the eligibility and enrollment processes for the counties by eliminating the need for additional levels of eligibility determination if a person is in need of services covered under the existing Medi-Cal benefit package, but not under the benchmark benefit package provided to the expansion population if the current Medi-Cal benefit package is not chosen for the expansion population. For example, if an individual is eligible under the Medi-Cal expansion, but also eligible for the current Medi-Cal program because he or she is disabled or in need of long-term services and support services (such as In-Home Supportive Services) that are not covered by the more narrow benchmark benefit packages, such an individual will seek coverage under the existing Medi-Cal program to obtain these additional services. Such an individual would have to go through an additional eligibility determination, and the state may only receive the regular 50 percent federal matching rate (instead of the enhanced matching rate in the ACA).

- Economic stimulus benefit of enhanced federal funding from broader benefit package. States have an economic incentive to provide an enhanced benefit package for the expansion population because the broader benefit package will draw additional federal Medicaid funds into the California economy because the expansion population is eligible for 100 percent federal financing for the first three years of the expansion. As noted previously, the enhanced federal funding reduces to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and thereafter.

- Exemptions from benchmark benefit packages would be costly to administer. Federal Medicaid law prevents certain groups from being required to enroll in benchmark or benchmark equivalent benefits. For example, pregnant women, individuals who are blind or disabled, individuals dually eligible for Medicare and Medicaid, terminally ill individuals receiving hospice care under Medi-Cal, medically frail individuals and other groups (known as "exempt individuals" in federal regulation) can be offered benchmark or benchmark-equivalent coverage, but are not required to enroll. Federal regulations require states to offer exempt individuals the option to enroll in benchmark or benchmark equivalent coverage but require states to inform individuals that enrollment is voluntary, and that they may disenroll at any time. Federal regulations also require states to inform individuals of the difference in the benefit packages prior to enrollment, and to document that the individual was informed prior to enrollment in the individual's eligibility file.

4. **Legislative Analyst's Office (LAO) Report**. In February 2013, the LAO released a report entitled "Examining the State and County Roles in the Medi-Cal Expansion." The LAO

states the expansion would likely have significant policy benefits, including improved health outcomes for the newly eligible Medi–Cal population. In the short term, fiscal savings to the state as a whole would far outweigh the nonfederal costs associated with providing health care to the expansion population. After a decade, when the enhanced federal matching rate is reduced from 100 percent to 90 percent, the LAO estimates that overall savings to the state as a whole (state and local governments) would likely continue to outweigh costs. Despite the significant uncertainty about the long–term costs and savings associated with the expansion, on balance, the LAO believes the policy merits of the expansion and the fiscal benefits that are likely to accrue to the state as a whole outweigh the costs and potential fiscal risks. The LAO recommends the state adopt the optional expansion.

The LAO also states that it finds that the state is in a better position than the counties to effectively organize and coordinate the delivery of health services to the newly eligible population—potentially resulting in improved health outcomes and administrative efficiencies. As a practical matter, the LAO also believes the state is better positioned than the counties to successfully implement an expansion by January 1, 2014. The LAO recommends the Legislature adopt a state–based expansion, shifting the fiscal and programmatic responsibility of providing health care to the expansion population from counties to the state. Given this shift of responsibility, the LAO further finds that implementation of a state–based approach results in the need for a reexamination of state–county funding arrangements for indigent health care. Accordingly, the LAO recommends the Legislature redirect a portion of funding currently allocated to counties under 1991 realignment for indigent health.

**5. Related legislation**

AB X1 1 (John A. Pérez) is identical to this measure. *ABX1 1 was heard in the Assembly Health Committee on February 19, 2013, and passed on a 13-6 vote.*

SB X1 3 (Hernandez) establishes legislative intent to create a bridge option that allows low-cost health coverage to be provided to individuals within Covered California. *SBX1 3 is pending referral in the Senate Rules Committee.*

SB 28 (Hernandez and Steinberg) implements various provisions of the ACA regarding Medi-Cal eligibility and program simplification including the use of the MAGI and expansion of eligibility in the Medi-Cal program and is substantially similar to SB X1 1. SB 28 is currently in the Senate Health Committee.

AB 50 (Pan) implements various provisions of the ACA related to allowing hospitals to make a preliminary determination of Medi-Cal eligibility, allows forms for renewal to be prepopulated with existing available information and requires the process for Medi-Cal enrollees to choose a plan to be coordinated with the Exchange. AB 50 is currently in the Assembly Health Committee.

**6. Prior legislation**

AB 43 (Monning) and SB 677 (Hernandez) of the 2011-2012 session were substantially similar to SB 28 of this session. *SB 677 died on the Assembly Inactive File and AB 43 died on the Senate Inactive File.*

SB 1487 (Hernandez) also from the 2011-2012 session would have required DHCS to extend Medi-Cal eligibility to youth who were formerly in foster care and who are under 26 years of age, subject to FFP being available and to the extent required by federal law. SB 1487 would have also made legislative findings and declarations regarding the ACA, stated legislative intent to ensure full implementation of the ACA, and to enact into state law any provision of the ACA that may be struck down by the United States Supreme Court. *SB 1487 was held on the Senate Appropriations Committee suspense file.*

7. **Support.** This bill is supported by Consumers Union, Health Access California, Western Center on Law & Poverty, the Congress of California Seniors, the California Labor Federation, the California Primary Care Association, the California Academy of Family Physicians, the American Cancer Society Cancer Action Network, and the American Heart Association, among others. Generally, proponents argue this bill is the largest expansion of Medi-Cal since 1966, will make 1.4 million Californians eligible for coverage and draw down an estimated $2.1 to $3.5 billion in federal funds in 2014 alone. This will help create jobs in the health care workforce, improve worker productivity, and increase local and state tax revenues. Proponents argue expanding Medi-Cal will extend lifesaving health coverage to millions, provide preventive care and improve health outcomes for those who receive coverage. Proponents cite specific provisions of the bill and federal law that they support, including the enhanced federal matching rate for the expansion population, the Medi-Cal coverage expansion to former foster youth and low-income adults, the extension of full scope benefits to pregnant women, the addition of the EHB to Medi-Cal coverage, the elimination of the deprivation and asset tests, and the program simplification provisions. Los Angeles County writes in support that there are 2.2 million uninsured people in Los Angeles County, and half of these individuals will be eligible for Medi-Cal benefits, including many of the 240,000 participants in its LIHP.

8. **Support in concept**. The California State Council of the Service Employees International Union (SEIU) supports this bill in concept as it supports full implementation of the ACA. SEIU states it would like to continue discussions aimed at ensuring there will be increased access to high quality affordable health care and raise provider rates, which are presently inadequate. SEIU supports finding new revenue sources to ensure adequate long term financing for expanded access to high quality health care and ensuring the state maintains funding for the public and private safety-net health care systems. SEIU states it will continue working with the Legislature and Governor on developing clear protocols and coordination between county Medi-Cal eligibility operations and Covered California that supports all Californians seeking coverage.

9. **Support and request amendments**. Organizations including the California Pan-Ethnic Health Network, the Latino Health Alliance, the California Immigrant Policy Collaborative, PICO California, California School Health Centers, Latino Coalition for a Healthy California, the Alliance for Boys and Men of Color Health Policy Work Group, the Children's Defense Fund, PolicyLink, the California Health Advocates, and the California Primary Care Association write in support but ask that this bill be amended to include within the Medi-Cal expansion all legal permanent resident adults with incomes less than 138 percent of the FPL. These groups argue refusing to act will result in many low-income immigrants being denied access to affordable coverage in 2014, and immigrants earning less than $15,856 a year will be required to pay monthly premiums and out-of-pocket expenses that are unaffordable.

Children Now writes in support and requests amendments to specify that DHCS work with community-based organizations and other stakeholders to design an effective outreach plan and that the former foster youth expansion be implemented immediately for people aging out of Medi-Cal so as to achieve parity with young adults who have not been in foster care.

The California Association of Public Hospitals writes in support of this bill and also suggests amendments to help maintain continuity of care, minimize confusion for enrollees, and conform to with the Administration's LIHP transition plan.

The California Opioid Maintenance Providers (COMP) write in support but also requests that language in this bill specifically states that all current Medi-Cal benefits, including the optional benefits delivered through Drug Medi-Cal must be covered. COMP states ensuring coverage of those services provided through the Drug Medi-Cal Program will yield significant outcomes and savings.

**SUPPORT AND OPPOSITION:**

**Support:** Alliance for Boys and Men of Color
American Cancer Society Cancer Action Network
American Federation of State, County, and Municipal Employees
American Heart Association
California Academy of Family Physicians
California Association of Public Hospitals and Health Systems
California Coverage and Health Initiatives
California Health Advocates
California Hospital Association
California Immigrant Policy Center
California Labor Federation
California Mental Health Directors Association
California Nurses Association
California Opioid Maintenance Providers
California Pan-Ethnic Health Network
California Primary Care Association
California School Employees Association, AFL-CIO
California School Health Centers Association
California State Association of Counties
Californians for Patient Care
Children Now
Children's Defense Fund California
Congress of California Seniors
Consumers Union
County Welfare Directors Association of California
Epilepsy California
Health Access California
Latino Health Alliance
Los Angeles County Board of Supervisors
March of Dimes Foundation – California Chapter
National Association of Social Workers – California chapter
National Health Law Program

PICO California
Planned Parenthood
San Mateo County Central Labor Council
Service Employees International Union
The Children's Partnership
The Greenlining Institute
Transgender Law Center
United Ways of California
Western Center on Law and Poverty
100% Campaign

**Oppose:** None received

**-- END --**