Medi-Cal to Covered California Enrollment Program (Senate Bill 260) Frequently Asked Questions

Overview

The California legislature passed Senate Bill 260 (Statutes of 2019, Chapter 845), which directed the following:

1. Covered California will automatically enroll individuals who lose Medi-Cal coverage and gain eligibility for subsidized coverage into the lowest cost silver plan available, unless information is available that allows Covered California to enroll consumers into the same Qualified Health Plan (QHP) as their previous Medi-Cal managed care plan.
2. The transition from Medi-Cal to Covered California must take place before the individual's Medi-Cal coverage is terminated.
3. The coverage effective date must be the first of the month following termination of Medi-Cal coverage to prevent any coverage gaps.

Due to the COVID-19 public health emergency (PHE), California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) changes were delayed until June 2022.

This Frequently Asked Questions (FAQ) document serves as a resource – it will be updated as new information is obtained or policies are developed.

Frequently Asked Questions: Table of Contents

Overview 1

FREQUENTLY ASKED QUESTIONS (FAQ) AND ANSWERS 2

General Questions 2

1. What is the Medi-Cal "continuous coverage" (or maintenance of effort) requirement? 2
2. What are the general reasons that a Medi-Cal beneficiary would be determined ineligible for coverage through the Department of Health Care Services (DHCS)? How does this impact their Covered California automatic plan selection (APS) eligibility? 3
3. Within the Medicaid unwinding process, states may have a reasonable compatibility threshold flexibility when it comes to the Medicaid redeterminations. What Federal Poverty Level (FPL) range will be the cutoff for the SB 260 Medi-Cal Transitioners (MCTs)? 3
4. How is DHCS, the administrator for the Medi-Cal program, preparing for the unwinding of Medi-Cal continuous coverage? 4
5. When will the COVID-19 Public Health Emergency end? 4
6. How is Covered California supporting DHCS, the administrator for the Medi-Cal program, with the unwinding of the Medi-Cal continuous coverage requirement? 4
7. What should people do if they lose their Medi-Cal coverage? 4
8. Will there be a new Special Enrollment Period (SEP) for consumers who lose their Medi-Cal to enroll in Covered California? 5

Covered California SB 260 Implementation 5

9. What is Covered California's Auto Enrollment Policy? 5
10. What is Covered California's Opt-in policy? 5
11. What is Covered California's Opt-out policy? 5
12. What is the current APS enrollment hierarchy? 5

13. When a dependent is an MCT, what is the system logic and which plan can they be moved to? 6
14. How will Covered California meet the noticing requirements of SB 260? 6
15. Will the notices be sent to consumers in the preferred language that Medi-Cal has on file? 6
16. Will MCTs be able to find help online? 6
17. If a Medi-Cal Transitioner (MCT) creates a new account other than the account that was created initially for them, how will this impact their application? Will it be considered a duplicate application? 7
18. If an MCT goes through the APS process with $0 Premium, and is later determined to be Medi-Cal eligible retroactively, how will the APTC used by the consumer be reconciled for taxes? 7
19. What is Covered California's timing around consumer noticing after DHCS sends notice of discontinuance letter to Medi-Cal beneficiaries? 7
Certified Enrollment Counselors 7
20. What can Covered California certified enrollment partners (agents, navigators, counselors) do to support Medi-Cal enrollees? 7
21. Can an enroller check to see if the consumer who is not delegated to them is a Medi-Cal Transitioner with an existing account before creating a new application? 8
22. Is there a QR code or link for the consumer to easily delegate their application to a certified agent or counselor on their account creation page, if they don't already have one? 8
23. If the consumer does have a delegated certified enroller, will the certified enroller information be on the account creation page for them to contact if they need help? 8

FREQUENTLY ASKED QUESTIONS (FAQ) AND ANSWERS

General Questions

1. What is the Medi-Cal "continuous coverage" (or maintenance of effort) requirement?

- In March 2020, as part of COVID-19 relief legislation, Congress provided increased Medicaid funding to states. As a prerequisite to receiving these funds the U.S. Department of Health and Human Services (HHS) implemented a "continuous coverage" requirement that prohibits states from terminating most Medicaid enrollees' coverage until after the public health emergency (PHE) ends.
- The Consolidated Appropriations Act, 2023, which took effect December 29, 2022, delinked the Medi-Cal continuous coverage requirement from the ending of the PHE.
    - The Medi-Cal continuous coverage requirement ended on March 31, 2023.

 - On April 1, 2023, Medi-Cal resumed its annual eligibility review process, and states may discontinue/terminate coverage for individuals who no longer meet the eligibility requirements for health insurance through Medi-Cal.

2. What are the general reasons that a Medi-Cal beneficiary would be determined ineligible for coverage through the Department of Health Care Services (DHCS)? How does this impact their Covered California automatic plan selection (APS) eligibility?

- DHCS believes that many Medi-Cal Transitioners (MCTs) will lose their coverage due to increases in their income that push them over the Medi-Cal eligibility threshold.
  - These consumers will likely be eligible for subsidies and will likely be included in Covered California's Automatic-Plan Selection process.
- There has been expressed concern that a large percentage of Medi-Cal beneficiaries who are eligible for coverage but not for subsidies will be the result of procedural denials by DHCS which include:
  - Failure to respond in a timely manner to requests for information necessary to determine Medi-Cal or the California Child Health Insurance Program (CCHIP) eligibility.
  - Failure to document citizenship or eligible immigration status during a reasonable opportunity period.
  - Failure to comply with assignment of rights or medical child support cooperation requirements.
  - Failure to apply for other benefits for which the individual may be eligible.
  - Failing to follow-up to the counties and/or DHCS with proper documentation and submission of household income information needed to process their redetermination.
  - In the event of a procedural denial, the consumer will not be included in the APS process.

3. Within the Medicaid unwinding process, states may have a reasonable compatibility threshold flexibility when it comes to the Medicaid redeterminations. What Federal Poverty Level (FPL) range will be the cutoff for the SB 260 Medi-Cal Transitioners (MCTs)?

- DHCS recently adopted a 20% reasonable compatibility threshold, as explained in their Medi-Cal-COVID-19-PHE-Unwinding-Plan (page 23), which is used to evaluate whether the income information reported by a beneficiary is compatible with federal sources when determining MAGI Medi-Cal income eligibility.
- Per SB 260, eligible individuals will be transitioned to Covered California only after the county determines them ineligible for Medi-Cal and they are found eligible for subsidies.
- Nothing has changed regarding the FPL percentages at which a consumer is determined ineligible for Medi-Cal and eligible for Covered California

4. How is DHCS, the administrator for the Medi-Cal program, preparing for the unwinding of Medi-Cal continuous coverage?

- According to DHCS, the unwinding of federal Medicaid continuous coverage requirement necessitates a coordinated, phased communications plan to reach beneficiaries with messages across multiple channels using trusted messengers. This approach has three primary elements:
  - **Educate** – Raise awareness of actions beneficiaries need to take and when they need to take them to maintain coverage.
  - **Engage** – Engage community partners with necessary tools for reaching beneficiaries.
  - **Provide Consistency** – Create a consistent voice across community partners.
- DHCS has provided:
  - *Medi-Cal Continuous Coverage Resources*
  - *Medi-Cal Continuous Coverage Communication Toolkit*
  - *Medi-Cal PHE Unwind Operational Plan (Updated January 13th, 2023)*

5. When will the COVID-19 Public Health Emergency end?

- On Monday, January 30, 2023, President Biden announced that the COVID-19 Public and National Health Emergency would end on May 11, 2023. As noted above, the beginning of the SB 260 Medi-Cal Transitioner (MCT) Automatic-Plan Selection (APS) process is no longer linked to the ending of the COVID-19 PHE.

6. How is Covered California supporting DHCS, the administrator for the Medi-Cal program, with the unwinding of the Medi-Cal continuous coverage requirement?

- The California Healthcare, Eligibility, Enrollment, and Retention System (CalHEERS) has been ready to perform the automatic plan selection for qualifying consumers since June 2022. The functionality includes a configuration that allows Covered California to choose when the system changes will go live.
- DHCS has calculated that the first Medi-Cal redetermination will occur on May 19, 2023.
- Covered California instructed CalHEERS to turn on the SB 260 functionality on May 19, 2023. This date runs parallel to DHCS's Medi-Cal Continuous Coverage unwinding processes.

7. What should people do if they lose their Medi-Cal coverage?

- SB 260 requires Covered California to automatically enroll people who lose their Medi-Cal coverage and gain eligibility for subsidized coverage into the lowest cost silver plan available in their region.
- Consumers who are not captured in Covered California's APS process can contact the Service Center and speak to a representative. Certified insurance agents and enrollment counselors can also provide consumers with assistance in enrolling in coverage.

8. Will there be a new Special Enrollment Period (SEP) for consumers who lose their Medi-Cal to enroll in Covered California?

- Loss of Minimum Essential Coverage (MEC) is a qualifying life event (QLE) for consumers who lose their coverage through Medi-Cal to enroll in Covered California via special enrollment period (SEP). These consumers will have 60 days before or after loss of MEC to enroll.

Covered California SB 260 Implementation

9. What is Covered California's Auto Enrollment Policy?

- To maintain compliance with the requirements of SB 260, and ensure consumers are given the opportunity to opt-in to coverage, Covered California will implement an APS process for the transitioning population. MCTs who are eligible or conditionally eligible for advance premium tax credit (APTC) and whose other household members are not already enrolled in a QHP through Covered California will generally be placed into the lowest cost silver plan available in the MCTs region with a pending enrollment status.

10. What is Covered California's Opt-in policy?

- For consumers with a non-zero-dollar net premium, plan effectuation will take place once they pay their binder payment.
- For consumers with a zero-dollar net premium, plan effectuation will occur after the MCT manually completes the opt-in process.

11. What is Covered California's Opt-out policy?

- MCTs with a non-zero premium can passively cancel their enrollment by not paying their binder payment.
- MCTs with a zero-dollar premium can passively cancel their enrollment by not opting-in.
- All MCTs can actively cancel their enrollment by using the opt-out feature within CalHEERS, or by calling the Covered California Service Center and using the interactive voice response system or speaking to a representative. Certified enrollment counselors can also provide MCTs with assistance.
- If a passive or active opt-out occurs, MCTs will retain their 60-day special enrollment period to apply for Covered California.

12. What is the current APS enrollment hierarchy?

- The current APS enrollment hierarchy functionality to evaluate an MCT for plan selection is as follows:
  - If there is one existing enrollment, and it is a non-Catastrophic plan, the consumer will be added to the existing enrollment.
  - If there is one existing enrollment, and it is a Catastrophic plan, the consumer will be put into the Lowest Cost Silver Plan, or the Lowest Cost AI/AN plan based on eligibility.

  - If there are multiple enrollments, but one of them is the Lowest Cost Silver (or Lowest Cost AI/AN) plan, the member will be auto added to the existing plan.
  - If there are no existing active enrollments, the consumer will be put into the Lowest Cost Silver Plan or the Lowest Cost AI/AN plan, based on eligibility.
  - If none of the above categories fit, the consumer will be put into the Lowest Cost Silver Plan, or the Lowest Cost AI/AN plan based on eligibility.

13. When a dependent is an MCT, what is the system logic and which plan can they be moved to?

- If a dependent becomes newly eligible to Covered CA and there is only one existing family enrollment, regardless of age, the dependent will be added to the existing plan.
  - Exception: If the only enrollment is a Minimum Coverage plan, the dependent will be put into their own Lowest Cost Silver plan.

14. How will Covered California meet the noticing requirements of SB 260?

- Covered California will send customized notices to MCTs to explain their plan enrollment and financial assistance amounts; options to keep, change or cancel coverage; a statement that services received during the first month of enrollment will only be covered by the plan if the premium is paid by the due date; and how to get help.
  - For $0 net premium MCTs, the noticing statement will explain that services received during the first month will only be covered by the plan if the MCT opts-in to coverage by the due date.
- Notice packets will also include educational material to address frequently asked questions related to Marketplace coverage, plan benefits and cost sharing, key insurance terms and health insurer options.

15. Will the notices be sent to consumers in the preferred language that Medi-Cal has on file?

- Yes. All eligibility notices will be in the language that the consumer has selected on their application. However, microsites will only be in English and Spanish, as is CalHEERS.

16. Will MCTs be able to find help online?

- Yes. Covered California will provide a dedicated landing page on our CoveredCA.com site for MCTs to efficiently direct them to their account information. Once logged in to CalHEERS, MCTs will see a specially designed “dashboard” showing their pre-selected plan, coverage effectuation options and short-cuts to search for a preferred provider, shop for a different plan, and update account information.

17. If a Medi-Cal Transitioner (MCT) creates a new account other than the account that was created initially for them, how will this impact their application? Will it be considered a duplicate application?

- If the consumer chooses to create a new account, CalHEERS will prompt a warning message telling the MCT that they already have an application in the system and may want to link to the existing application.
  - If the consumer bypasses the Microsite and attempts to create an account through the CoveredCA.com page, they will see an option specifically for the MCT population.
- If the consumer still completes a new application, this will create a duplicate application that could result in major system, enrollment, and consumer problems such as:
  - New Covered California case will not be linked to the MCT consumer's previous SAWS case. Consequently, updates for one enrollment will not be transferred to the new case.
  - Overconsumption of APTC if both enrollments were approved for financial assistance. In this event, the consumer will be responsible for reconciliation at tax time.
  - Consumer confusion when receiving multiple notices with potentially different eligibility results and plan details.
  - Increased number of consumers with an erroneous carry forward status.

18. If an MCT goes through the APS process with $0 Premium, and is later determined to be Medi-Cal eligible retroactively, how will the APTC used by the consumer be reconciled for taxes?

- The consumer must reconcile the APTC received during the benefit year with the IRS at tax time. However, the consumer won't be responsible for paying back any APTC they received during the months of retroactive Medi-Cal eligibility/enrollment under the IRS regulation.

19. What is Covered California's timing around consumer noticing after DHCS sends notice of discontinuance letter to Medi-Cal beneficiaries?

- The Covered CA eligibility and enrollment notice (NOD01T) will be sent a couple days after we receive the determination that results in Medi-Cal discontinuance.

Certified Enrollment Counselors

20. What can Covered California certified enrollment partners (agents, navigators, counselors) do to support Medi-Cal enrollees?

- Covered California has developed an SB 260/Medi-Cal to Covered California Enrollment Program Toolkit that will be updated regularly to equip our certified enrollment partners with the necessary resources to best serve the MCT consumer population. Covered California certified enrollment partners can also support the MCT

population with updating applicant information, understanding their coverage options, and opting into coverage.
- For additional resources please refer to Question #4.

21. Can an enroller check to see if the consumer who is not delegated to them is a Medi-Cal Transitioner with an existing account before creating a new application?

- No, a certified enroller not delegated to a consumer cannot check if the consumer is a Medi-Cal Transitioner nor access their case. However, the consumer may delegate the enroller to access their case and check if the consumer is a Medi-Cal Transitioner.
- For any consumer not currently delegated to the enroller or would like to change delegation, the new enroller can use the Accelerated Consumer Delegation Consent Tool in CalHEERS. The Accelerated Consumer Delegation Consent Tool can be found via a link title, “Delegation Tool” in the CalHEERS Enroller Portal under the Quick links section. The Delegation Tool will check the consumers details against existing cases in CalHEERS and provides an on-screen alert to the enroller of possible existing duplicate cases.
- For consumers currently delegated to an enroller and is working with them, the delegated enroller can access the consumer case and check if they are a Medi-Cal Transitioner.
- If a Medi-Cal Transitioner already has a case in CalHEERS with an active Certified Enroller delegation, the transaction (834) to the carrier should include the Agent delegation information.

Certified enrollers should regularly check their secure mailbox to identify which consumers have transitioned to Covered California – this will be indicated by a Portal Alert titled “**Auto Plan Selection**”. Additional information can be found in the consumer’s Documents and Correspondence page in the notice titled, “**Eligibility Notice - Medi-Cal to Covered California”.**

22. Is there a QR code or link for the consumer to easily delegate their application to a certified agent or counselor on their account creation page, if they don’t already have one?

- No, this functionality is not available.

23. If the consumer does have a delegated certified enroller, will the certified enroller information be on the account creation page for them to contact if they need help?

- While the delegated enroller will not be on the account creation page, it will be in the eligibility notice (NOD01T) and will be viewable in the consumer’s account under the Manage Delegates area.