Department of Health Care Services
Proposed Trailer Bill Legislation

Medicaid Final Rules

FACT SHEET

Issue Title: Medicaid Final Rules. To implement three Medicaid Final Rules, the Department of Health Care Services (DHCS) proposes to 1) establish timeframes for acting on changes in circumstances, determining and redetermining eligibility, and implementing processes to obtain updated in-state Medi-Cal member addresses through reliable third-party data sources in order to align with the federal Medicaid Eligibility Final Rule; 2) authorize DHCS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis to implement the Managed Care and Access Final Rules, and 3) extend the sunset date for Medicaid Managed Care Network Adequacy Standards from January 1, 2026, to January 1, 2029.

Background:
Medicaid Eligibility Final Rule
The Centers for Medicare and Medicaid Services (CMS) issued two significant Medicaid eligibility final rules (Part 1 and Part 2) in September 2023 and April 2024. Together, Part 1 and 2 are referred to as the Medicaid Eligibility Final Rule. The final rule simplifies application, eligibility determination, enrollment, and renewal processes for Medicaid and the Children's Health Insurance Program (CHIP). It reduces application complexity, integrates data systems to streamline eligibility, and enhances program accessibility. Implementation dates for states to comply range from December 2025 to June 2027. To comply with the Medicaid Eligibility Final Rule, DHCS must make significant changes to Medi-Cal eligibility statutes, regulations, policies, timelines, and processes related to applications, renewals, change of circumstances, and return mail processes.

The Medicaid Eligibility Final Rule included a total of 16 regulatory provisions with each having different compliance due dates. Among these, the focus is on the three key provisions described below.

Act on Updated Address Information (42 Code of Federal Regulations (CFR) Sections 435.919 and 457.344): The Medicaid Eligibility Final Rule permanently allows counties to implement processes to obtain updated in-state address information from reliable third-party sources regularly and to act on these changes without further verification so that eligible individuals do not lose coverage when their address changes.

In accordance with the new Medicaid Eligibility Final Rule, one of the identified reliable sources is the use of the National Change of Address (NCOA) database. Individuals who need to update their address, may do so by submitting a Change of Address (COA) to the United States Postal Service (USPS). USPS in turn submits the updated address to the NCOA database. NCOA is a secure system of record for all COA requests who have filed a change-of-address with the Postal Service.

During the continuous coverage COVID-19 public health emergency unwinding, select counties integrated information returned from the NCOA into the California Statewide Automated Welfare System (SAWS). The use of the NCOA enabled counties to review the mailing address and make the appropriate updates with new addresses prior to mailing, to confirm the Medi-Cal member addresses are up to date, reducing the volume of undeliverable or returned mail. Additionally, address accuracy provides that Medi-Cal members receive renewal notices, benefit updates, and other critical information, reducing the risk of losing coverage due to undelivered mail. This provision requires California to expand the use of the NCOA database to provided updated address information to all counties beginning December 1, 2025.

Timeframes for Acting on Changes in Circumstance (42 CFR Sections 435.919 and 457.344): The Medicaid Eligibility Final Rule provision for changes in circumstances requires the creation of timeliness standard for counties to process reported and anticipated changes. For reported changes in circumstances, Medi-Cal eligibility must be redetermined by the end of the month that occurs 30 calendar days from the reported change in circumstances, or by the end of the month that occurs 60 calendar days from the reported change in circumstances when additional information is required.

Additionally, the Medicaid Eligibility Final Rule prohibits termination of Medi-Cal when a reported or discovered change in circumstance appears to be beneficial to the Medi-Cal member's eligibility, but the Medi-Cal member does not respond to requests for additional information. For anticipated changes in circumstances, Medi-Cal must be redetermined by the end of the month in which the anticipated change occurs, or by the end of the month following the anticipated change when additional information is required. If the change in circumstances would not result in a reduction or loss of benefits and the Medi-Cal member fails to submit the requested information, the county cannot terminate Medi-Cal.

Currently, there is no timeliness standard for county processing of changes in circumstance in existing law. When a change of circumstance is reported, the county will request additional information and use available information sources. A Medi-Cal member can currently be disenrolled if information cannot be verified using available information sources and they do not respond to the request for verification, even if the change would not result in a reduction or loss of benefits. With this change, the county can avoid unnecessary administrative work related to terminating and reinstating coverage should the Medi-Cal member respond after discontinuance, and the Medi-Cal member will continue to have access to care without any gaps in coverage. These changes under the Medicaid Eligibility Final Rule also provide that eligibility determinations based on a change in circumstance happen in a timely manner.

DHCS must come into compliance by June 1, 2027.

Timely Determination and Redetermination of Eligibility (42 CFR Sections 435.907, 435.912, 457.340(d) and 457.1170): The Medicaid Eligibility Final Rule provisions require establishing standard timelines for when individuals need to provide additional information at application and updating timeliness standards for county processing of annual renewals. Counties must provide Medi-Cal applicants with a reasonable period to respond to requests for information with a minimum of 15 calendar days and establish a reconsideration period of 90 calendar days at application. DHCS must also update timeliness standards for counties to process annual renewals. Medi-Cal eligibility must be redetermined by either the end of the eligibility period when information is received with more than 30 calendar days left in the eligibility period or by the end of month following the end of eligibility period when information is received with less than 30 calendar days left in the eligibility period.

Currently, DHCS requires counties to issue two 10-day requests to gather additional information to complete the application and there is no current reconsideration period for applications. For annual renewals, counties only have until the end of the eligibility period to redetermine Medi-Cal eligibility even when the renewal is submitted later in the month by the Medi-Cal member, or when they need to be considered for other Medi-Cal programs.

DHCS must come into compliance by June 1, 2027.

Managed Care and Access Final Rules

On April 22, 2024, CMS released two highly anticipated final rules. The first rule, which focuses on managed care delivery systems, is Managed Care Access, Finance, and Quality, known as the Managed Care Final Rule (CMS-2439-F). The second final rule, which focuses on fee-for-service (FFS) delivery systems and program improvements for home and community-based services (HCBS) across delivery systems, is Ensuring Access to Medicaid Services, known as the Access Rule (CMS-2442-F). Together, these rules reshape the federal regulatory landscape for Medicaid with respect to maintaining access to care, transparency, quality measurement, and oversight of provider payment rates. The issuance of these rules represents the most significant change to Medicaid regulations since CMS established the Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care (April 25, 2016) final rule.

Managed Care Final Rule

The Managed Care Final Rule adopts new standards for access to care through the managed care delivery systems administered by DHCS and introduces new enhanced requirements related to access, quality and finance, with varying effective dates starting July 9, 2024, and going through July 1, 2029. The revisions to the Managed Care Final Rule specifically strengthen standards for timely access to care, enhance quality and fiscal standards for state-directed payments, specify in lieu of services (ILOS) and settings to address health-related social needs, further specify medical loss ratio requirements, and establish a quality rating system for Medi-Cal managed care plans.

While DHCS is currently in compliance with many of these provisions, the timelines to

implement some of the new Managed Care Final Rule requirements with significant technology changes are more stringent. The first new technology change must be in place by July 2027 to meet CMS' timelines for implementation.

Pursuant to federal regulations, CMS requires states to set quantifiable network adequacy standards to ensure access to care for Medicaid members in the Medi-Cal Managed Care Delivery System, the County Mental Health Plans, Drug Medi-Cal Organized Delivery Systems, and Dental Managed Care (Title 42 CFR Sections 438.68 and 438.206). The State of California codified its managed care network adequacy standards in Welfare and Institutions Code (WIC) Section 14197, which requires the various delivery systems to meet time or distance standards based on the population density of the county for designated provider types and ensure timely access to covered health care services by meeting appointment time standards.

Existing law has a sunset date of January 1, 2026 for the network adequacy standards across delivery systems. The sunset date was previously extended by SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022) from January 1, 2023, to January 1, 2026.

The Access Rule
The Access Final Rule establishes new requirements for Medi-Cal stakeholder engagement, for Medi-Cal FFS payment rate changes, and a comprehensive expansion of current requirements for Home and Community-Based Services (HCBS) program standards and processes with effective dates ranging from July 9, 2024, to July 9, 2030. Key components include the establishment of a new Medi-Cal member advisory council, strengthening current stakeholder groups, and new transparency, analytic, and consultation requirements for Medi-Cal FFS provider rates. In addition, the Access Final Rule introduces a significant set of new requirements for HCBS programs, including new standards and reporting requirements related to person-centered service plans, waiting lists, and other access measures; a requirement to establish an incident management system; a requirement to establish a grievance system for HCBS delivered through a FFS delivery system; new regulatory framework to require reporting of performance measures from the national HCBS Quality Measure Set; and a new provision requiring at least 80 percent of Medicaid payments to certain direct care workers be spent on compensation for the direct care worker providing the services, as opposed to administrative overhead or profit. The first new technology change must be in place by July 2026 (HCBS FFS Grievance System) in order to meet CMS's timelines for implementation.

Justification For Change:
Medicaid Eligibility Final Rule
The Medicaid Eligibility Final Rule provisions, including the ability to act on updated address information, and the requirement to establish timeframes at application, renewal and changes in circumstances, are designed to improve the accuracy and efficiency of the eligibility determination process. By utilizing the NCOA and USPS as reliable sources for updated address information and setting clear timeframes for

processing eligibility determinations, these provisions ensure that individuals' eligibility status is based on the most current data, reducing delays and preventing incorrect coverage. Establishing fixed timeframes for addressing application and renewal processing further streamlines the process, ensuring applicants experience timely determinations and fewer gaps in coverage, ultimately promoting greater access to health care services while maintaining program integrity. Additionally, each provision above aims to streamline and reduce overall administrative workload and California's ongoing goal of reducing administrative churn, a critical issue for Medi-Cal members who frequently face eligibility barriers.

In order to align state law with these federal requirements, the proposed trailer bill language would:

- Make technical cleanup to remove inoperative sections and other conforming changes (WIC Sections 14011(d)(1) (amended by Statutes of 2023, Chapter 42, SEC. 102) and 14011(g) (Added by Statutes of 2023, Chapter 42, SEC. 109)), as needed.
- Require the county to provide Medi-Cal members a reasonable period of time (no less than 15 calendar days) to respond if the county needs to request additional information to determine and verify eligibility, as specified (WIC Section 14011 (d)(1) (Added by Statutes of 2023, Chapter 42, SEC. 109).
- Require the county to treat the additional information as a new application and reconsider eligibility without requiring a new application, if the applicant submits additional information required for determination within 90 calendar days after the date of denial (WIC Section 14011 (d)(2) (Added by Statutes of 2023, Chapter 42, SEC. 109)).
- Authorize DHCS to implement the section through an All-County Welfare Directors Letter without taking any further regulatory action (WIC Sections 14011 (h) (Added by Statutes of 2023, Chapter 42, SEC. 109), 14005.36(f), and 14005.37(w)).
- Require the changes in the TBL only be implemented after the DHCS Director determines that the California Statewide Automated Welfare System (CalSAWS) and the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) systems have been programmed, but no sooner than June 1, 2027 (WIC Sections 14011 (i) (Added by Statutes of 2023, Chapter 42, SEC. 109), 14005.36(g), and 14005.37(z)).
- Require the changes in the TBL to be implemented only to the extent required under federal law, after any necessary federal approvals are obtained, and if federal financial participation is available and not otherwise jeopardized. (WIC Sections 14011(k), 14005.36(i), and 14005.37(ab).
- Require the county to obtain updated, in-state address information from reliable, third-party sources without additional verification from the beneficiary, as specified (WIC Section 14005.36(a)(1) and (2)).
- Prohibit the period of redetermination of eligibility to exceed specified timeframes when a Medi-Cal member returns a renewal form (WIC Section 14005.37(f)(5)).

- Require the county to complete a redetermination, as specified, following the county's receipt of information related to the change in circumstances (WIC Section 14005.37(g)(4) and (5)).
- Prohibit a county from terminating a Medi-Cal member's coverage based on the change in circumstance, if a change in circumstance does not result in a negative action and the Medi-Cal member does not submit requested information (WIC Section 14005.37(g)(6)).

Managed Care and Access Final Rules
To minimize risks for noncompliance with federal regulations, including timelines, DHCS proposes flexible contracting mechanisms that allow the department to expedite vendor partnerships, resource allocation, and operational readiness. This approach addresses risks associated with losing federal program approvals, experiencing unstable Medi-Cal funding, and falling short of critical policy objectives due to unnecessary procedural delays (WIC Section 14197.9(c)).

In addition, DHCS proposes to extend the sunset date that outlines the network adequacy standards for Medi-Cal managed care plans, dental managed care plans, and County Behavioral Health Plans from January 1, 2026, to January 1, 2029 (WIC Section 14197(l)). DHCS relies on existing law as the regulatory authority to hold the plans listed above accountable to network adequacy standards, maintain access to care for Medi-Cal members, and comply with federal regulations.

By extending the sunset date, DHCS will have sufficient time to continue to analyze the Managed Care Final Rule, engage with relevant stakeholders, and propose and implement a revised policy responding to additional network adequacy requirements as specified in the new Managed Care Final Rule. Federal regulations require DHCS to conduct analyses considering nine factors while developing or adjusting network adequacy standards (Title 42, CFR Section 438.68), which remain in the new rule.

Summary of Arguments in Support:
- The proposal aligns state law with federal requirements.
- The request reduces timelines and costs to implement both the Managed Care and Access Final Rules, thereby reducing the risk to the state of not receiving federal reimbursement for State Medicaid costs and the risk of CMS rescinding the CalAIM 1115 waiver and BH-CONNECT 1115 waiver.
- Extending the sunset date will provide DHCS time to further analyze the Managed Care Final Rule, engage with relevant stakeholders, and develop comprehensive adjustments to the network adequacy standards to comply with federal requirements.

BCP # and Title: 4260-303-BCP-2025-MR, Medicaid Managed Care, Access, and Eligibility Final Rules