

ASSEMBLY BILL

No. 50

Introduced by Assembly Member Pan

December 21, 2012

An act to amend and repeal Sections 14016.5 and 14016.6 of, and to add Sections 14011.66, 14016.54, and 15926.6 to, the Welfare and Institutions Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 50, as introduced, Pan. Health care coverage: Medi-Cal: eligibility: enrollment.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

This bill would require the department to establish a process in accordance with federal law to allow a hospital that is a participating Medi-Cal provider to elect to be a qualified entity for purposes of determining whether any individual is eligible for Medi-Cal and providing the individual with medical assistance during the presumptive eligibility period.

Existing law requires an applicant or beneficiary, as specified, who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, to personally attend a presentation at which the applicant or beneficiary is informed of managed care and fee-for-service options for receiving Medi-Cal benefits. Existing law requires the applicant or beneficiary to indicate in writing his or her

choice of health care options and provides that if the applicant or beneficiary does not make a choice he or she shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides. Existing law requires the department to develop a program, as specified, to implement these provisions.

This bill would repeal these provisions on January 1, 2015, and would require the department to implement a new process by January 1, 2015, to inform Medi-Cal enrollees of their options with regard to the delivery of Medi-Cal services, including fee-for-service, if available, and all managed care options. The bill would, in this regard, prohibit the department from extending, or exercising any options to extend, the term of any existing contracts under which a nongovernmental entity has responsibility for performing functions under the Medi-Cal Managed Health Care Options program, including enrolling or informing an applicant or enrollee of managed care plan choices, assigning an applicant or enrollee to a managed care plan, or informing applicants of, or processing applications or requests for, exemptions to enrollment.

Existing law requires the California Health and Human Services Agency, in consultation with specified entities, to establish standardized single, accessible application forms and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements.

This bill would require that an applicant or recipient of benefits under a state health subsidy program be given an option, with his or her informed consent, to have an application for renewal form prepopulated or electronically verified in real time, or both, as specified.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
 State-mandated local program: no.

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

- 1 SECTION 1. Section 14011.66 is added to the Welfare and
- 2 Institutions Code, to read:
- 3 14011.66. The department shall establish a process in
- 4 accordance with Section 1396a(a)(47)(B) of Title 42 of the United
- 5 States Code, effective January 1, 2014, to allow a hospital that is

1 a participating provider under the state plan to elect to be a
2 qualified entity for purposes of determining, on the basis of
3 preliminary information, whether any individual is eligible for
4 Medi-Cal under the state plan or under a federal waiver for
5 purposes of providing the individual with medical assistance during
6 the presumptive eligibility period.

7 SEC. 2. Section 14016.5 of the Welfare and Institutions Code
8 is amended to read:

9 14016.5. (a) At the time of determining or redetermining the
10 eligibility of a Medi-Cal program or Aid to Families with
11 Dependent Children (AFDC) program applicant or beneficiary
12 who resides in an area served by a managed health care plan or
13 pilot program in which beneficiaries may enroll, each applicant
14 or beneficiary shall personally attend a presentation at which the
15 applicant or beneficiary is informed of the managed care and
16 fee-for-service options available regarding methods of receiving
17 Medi-Cal benefits. The county shall ensure that each beneficiary
18 or applicant attends this presentation.

19 (b) The health care options presentation described in subdivision
20 (a) shall include all of the following elements:

21 (1) Each beneficiary or eligible applicant shall be informed that
22 he or she may choose to continue an established patient-provider
23 relationship in the fee-for-service sector.

24 (2) Each beneficiary or eligible applicant shall be provided with
25 the name, address, telephone number, and specialty, if any, of each
26 primary care provider, and each clinic participating in each prepaid
27 managed health care plan, pilot project, or fee-for-service case
28 management provider option. This information shall be provided
29 under geographic area designations, in alphabetical order by the
30 name of the primary care provider and clinic. The name, address,
31 and telephone number of each specialist participating in each
32 prepaid managed health care plan, pilot project, or fee-for-service
33 case management provider option shall be made available by
34 contacting either the health care options contractor or the prepaid
35 managed health care plan, pilot project, or fee-for-service case
36 management provider.

37 (3) Each beneficiary or eligible applicant shall be informed that
38 he or she may choose to continue an established patient-provider
39 relationship in a managed care option, if his or her treating provider
40 is a primary care provider or clinic contracting with any of the

1 prepaid managed health care plans, pilot projects, or fee-for-service
2 case management provider options available, has available capacity,
3 and agrees to continue to treat that beneficiary or applicant.

4 (4) In areas specified by the director, each beneficiary or eligible
5 applicant shall be informed that if he or she fails to make a choice,
6 or does not certify that he or she has an established relationship
7 with a primary care provider or clinic, he or she shall be assigned
8 to, and enrolled in, a prepaid managed health care plan, pilot
9 project, or fee-for-service case management provider.

10 (c) No later than 30 days following the date a Medi-Cal or
11 AFDC beneficiary or applicant is determined eligible, the
12 beneficiary or applicant shall indicate his or her choice in writing,
13 as a condition of coverage for Medi-Cal benefits, of either of the
14 following health care options:

15 (1) To obtain benefits by receiving a Medi-Cal card, which may
16 be used to obtain services from individual providers, that the
17 beneficiary would locate, who choose to provide services to
18 Medi-Cal beneficiaries.

19 The department may require each beneficiary or eligible
20 applicant, as a condition for electing this option, to sign a statement
21 certifying that he or she has an established patient-provider
22 relationship, or in the case of a dependent, the parent or guardian
23 shall make that certification. This certification shall not require
24 the acknowledgment or guarantee of acceptance, by any indicated
25 Medi-Cal provider or health facility, of any beneficiary making a
26 certification under this section.

27 (2) (A) To obtain benefits by enrolling in a prepaid managed
28 health care plan, pilot program, or fee-for-service case management
29 provider that has agreed to make Medi-Cal services readily
30 available to enrolled Medi-Cal beneficiaries.

31 (B) At the time the beneficiary or eligible applicant selects a
32 prepaid managed health care plan, pilot project, or fee-for-service
33 case management provider, the department shall, when applicable,
34 encourage the beneficiary or eligible applicant to also indicate, in
35 writing, his or her choice of primary care provider or clinic
36 contracting with the selected prepaid managed health care plan,
37 pilot project, or fee-for-service case management provider.

38 (d) (1) In areas specified by the director, a Medi-Cal or AFDC
39 beneficiary or eligible applicant who does not make a choice, or
40 who does not certify that he or she has an established relationship

1 with a primary care provider or clinic, shall be assigned to and
2 enrolled in an appropriate Medi-Cal managed care plan, pilot
3 project, or fee-for-service case management provider providing
4 service within the area in which the beneficiary resides.

5 (2) If it is not possible to enroll the beneficiary under a Medi-Cal
6 managed care plan, pilot project, or a fee-for-service case
7 management provider because of a lack of capacity or availability
8 of participating contractors, the beneficiary shall be provided with
9 a Medi-Cal card and informed about fee-for-service primary care
10 providers who do all of the following:

11 (A) The providers agree to accept Medi-Cal patients.

12 (B) The providers provide information about the provider's
13 willingness to accept Medi-Cal patients as described in Section
14 14016.6.

15 (C) The providers provide services within the area in which the
16 beneficiary resides.

17 (e) If a beneficiary or eligible applicant does not choose a
18 primary care provider or clinic, or does not select any primary care
19 provider who is available, the managed health care plan, pilot
20 project, or fee-for-service case management provider that was
21 selected by or assigned to the beneficiary shall ensure that the
22 beneficiary selects a primary care provider or clinic within 30 days
23 after enrollment or is assigned to a primary care provider within
24 40 days after enrollment.

25 (f) (1) The managed care plan shall have a valid Medi-Cal
26 contract, adequate capacity, and appropriate staffing to provide
27 health care services to the beneficiary.

28 (2) The department shall establish standards for all of the
29 following:

30 (A) The maximum distances a beneficiary is required to travel
31 to obtain primary care services from the managed care plan,
32 fee-for-service case management provider, or pilot project in which
33 the beneficiary is enrolled.

34 (B) The conditions under which a primary care service site shall
35 be accessible by public transportation.

36 (C) The conditions under which a managed care plan,
37 fee-for-service case management provider, or pilot project shall
38 provide nonmedical transportation to a primary care service site.

39 (3) In developing the standards required by paragraph (2), the
40 department shall take into account, on a geographic basis, the

1 means of transportation used and distances typically traveled by
2 Medi-Cal beneficiaries to obtain fee-for-service primary care
3 services and the experience of managed care plans in delivering
4 services to Medi-Cal enrollees. The department shall also consider
5 the provider's ability to render culturally and linguistically
6 appropriate services.

7 (g) To the extent possible, the arrangements for carrying out
8 subdivision (d) shall provide for the equitable distribution of
9 Medi-Cal beneficiaries among participating managed care plans,
10 fee-for-service case management providers, and pilot projects.

11 (h) If, under the provisions of subdivision (d), a Medi-Cal
12 beneficiary or applicant does not make a choice or does not certify
13 that he or she has an established relationship with a primary care
14 provider or clinic, the person may, at the option of the department,
15 be provided with a Medi-Cal card or be assigned to and enrolled
16 in a managed care plan providing service within the area in which
17 the beneficiary resides.

18 (i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with
19 the provider or managed care plan, pilot project, or fee-for-service
20 case management provider shall be allowed to select or be assigned
21 to another provider or managed care plan, pilot project, or
22 fee-for-service case management provider.

23 (j) The department or its contractor shall notify a managed care
24 plan, pilot project, or fee-for-service case management provider
25 when it has been selected by or assigned to a beneficiary. The
26 managed care plan, pilot project, or fee-for-service case
27 management provider that has been selected by, or assigned to, a
28 beneficiary, shall notify the primary care provider or clinic that it
29 has been selected or assigned. The managed care plan, pilot project,
30 or fee-for-service case management provider shall also notify the
31 beneficiary of the managed care plan, pilot project, or
32 fee-for-service case management provider or clinic selected or
33 assigned.

34 (k) (1) The department shall ensure that Medi-Cal beneficiaries
35 eligible under Title XVI of the Social Security Act are provided
36 with information about options available regarding methods of
37 receiving Medi-Cal benefits as described in subdivision (c).

38 (2) (A) The director may waive the requirements of subdivisions
39 (c) and (d) until a means is established to directly provide the
40 presentation described in subdivision (a) to beneficiaries who are

1 eligible for the federal Supplemental Security Income for the Aged,
2 Blind, and Disabled Program (Subchapter 16 (commencing with
3 Section 1381) of Chapter 7 of Title 42 of the United States Code).

4 (B) The director may elect not to apply the requirements of
5 subdivisions (c) and (d) to beneficiaries whose eligibility under
6 the Supplemental Security Income program is established before
7 January 1, 1994.

8 (l) In areas where there is no prepaid managed health care plan
9 or pilot program that has contracted with the department to provide
10 services to Medi-Cal beneficiaries, and where no other enrollment
11 requirements have been established by the department, no explicit
12 choice need be made, and the beneficiary or eligible applicant shall
13 receive a Medi-Cal card.

14 (m) The following definitions contained in this subdivision shall
15 control the construction of this section, unless the context requires
16 otherwise:

17 (1) "Applicant," "beneficiary," and "eligible applicant," in the
18 case of a family group, mean any person with legal authority to
19 make a choice on behalf of dependent family members.

20 (2) "Fee-for-service case management provider" means a
21 provider enrolled and certified to participate in the Medi-Cal
22 fee-for-service case management program the department may
23 elect to develop in selected areas of the state with the assistance
24 of and in cooperation with California physician providers and other
25 interested provider groups.

26 (3) "Managed health care plan" and "managed care plan" mean
27 a person or entity operating under a Medi-Cal contract with the
28 department under this chapter or Chapter 8 (commencing with
29 Section 14200) to provide, or arrange for, health care services for
30 Medi-Cal beneficiaries as an alternative to the Medi-Cal
31 fee-for-service program that has a contractual responsibility to
32 manage health care provided to Medi-Cal beneficiaries covered
33 by the contract.

34 (n) (1) Whenever a county welfare department notifies a public
35 assistance recipient or Medi-Cal beneficiary that the recipient or
36 beneficiary is losing Medi-Cal eligibility, the county shall include,
37 in the notice to the recipient or beneficiary, notification that the
38 loss of eligibility shall also result in the recipient's or beneficiary's
39 disenrollment from Medi-Cal managed health care or dental plans,
40 if enrolled.

1 (2) (A) Whenever the department or the county welfare
2 department processes a change in a public assistance recipient's
3 or Medi-Cal beneficiary's residence or aid code that will result in
4 the recipient's or beneficiary's disenrollment from the managed
5 health care or dental plan in which he or she is currently enrolled,
6 a written notice shall be given to the recipient or beneficiary.

7 (B) This paragraph shall become operative and the department
8 shall commence sending the notices required under this paragraph
9 on or before the expiration of 12 months after the effective date
10 of this section.

11 (o) This section shall be implemented in a manner consistent
12 with any federal waiver required to be obtained by the department
13 in order to implement this section.

14 (p) *This section shall remain in effect only until January 1, 2015,*
15 *and as of that date is repealed, unless a later enacted statute, that*
16 *is enacted before January 1, 2015, deletes or extends that date.*

17 SEC. 3. Section 14016.54 is added to the Welfare and
18 Institutions Code, to read:

19 14016.54. (a) On or before January 1, 2015, the department
20 shall implement a new process to inform Medi-Cal enrollees of
21 their options with regard to the delivery of Medi-Cal services,
22 including fee-for-service, if available, and all managed care options.
23 The process shall include a mechanism to allow enrollees to make
24 an informed choice and to pick a health plan and a primary care
25 provider. In developing the process, the department shall convene
26 public meetings to allow for input from stakeholders and other
27 members of the public, consult with counties and the Legislature,
28 and coordinate with the California Health Benefit Exchange.

29 (b) For purposes of implementing subdivision (a), the
30 department shall not extend, or exercise any options to extend the
31 term of any existing contracts under which a nongovernmental
32 entity has responsibility for performing functions under the
33 Medi-Cal Managed Health Care Options program, including
34 enrolling or informing an applicant or enrollee of managed care
35 plan choices, assigning an applicant or enrollee to a managed care
36 plan, or informing applicants of, or processing applications or
37 requests for, exemptions to enrollment.

38 SEC. 4. Section 14016.6 of the Welfare and Institutions Code
39 is amended to read:

1 14016.6. The State Department of Health *Care* Services shall
2 develop a program to implement Section 14016.5 and to provide
3 information and assistance to enable Medi-Cal beneficiaries to
4 understand and successfully use the services of the Medi-Cal
5 managed care plans in which they enroll. The program shall
6 include, but not be limited to, the following components:

7 (a) (1) Development of a method to inform beneficiaries and
8 applicants of all of the following:

9 (A) Their choices for receiving Medi-Cal benefits including the
10 use of fee-for-service sector managed health care plans, or pilot
11 programs.

12 (B) The availability of staff and information resources to
13 Medi-Cal managed health care plan enrollees described in
14 subdivision (f).

15 (2) (A) Marketing and informational materials including printed
16 materials, films, and exhibits, to be provided to Medi-Cal
17 beneficiaries and applicants when choosing methods of receiving
18 health care benefits.

19 (B) The department shall not be responsible for the costs of
20 developing material required by subparagraph (A).

21 (C) (i) The department may prescribe the format and edit the
22 informational materials for factual accuracy, objectivity and
23 comprehensibility .

24 (ii) The department shall use the edited materials in informing
25 beneficiaries and applicants of their choices for receiving Medi-Cal
26 benefits.

27 (b) Provision of information that is necessary to implement this
28 program in a manner that fairly and objectively explains to
29 beneficiaries and applicants their choices for methods of receiving
30 Medi-Cal benefits, including information prepared by the
31 department emphasizing the benefits and limitations to
32 beneficiaries of enrolling in managed health care plans and pilot
33 projects as opposed to the fee-for-service system.

34 (c) Provision of information about providers who will provide
35 services to Medi-Cal beneficiaries. This may be information about
36 provider referral services of a local provider professional
37 organization. The information shall be made available to Medi-Cal
38 beneficiaries and applicants at the same time the beneficiary or
39 applicant is being informed of the options available for receiving
40 care.

1 (d) Training of specialized county employees to carry out the
2 program.

3 (e) Monitoring the implementation of the program in those
4 county welfare offices where choices are made available in order
5 to assure that beneficiaries and applicants may make a
6 well-informed choice, without duress.

7 (f) Staff and information resources dedicated to directly assist
8 Medi-Cal managed health care plan enrollees to understand how
9 to effectively use the services of, and resolve problems or
10 complaints involving, their managed health care plans.

11 (g) The responsibilities outlined in this section shall, at the
12 option of the department, be carried out by a specially trained
13 county or state employee or by an independent contractor paid by
14 the department. If a county sponsored prepaid health plan or pilot
15 program is offered, the responsibilities outlined in this section shall
16 be carried out either by a specially trained state employee or by
17 an independent contractor paid by the department.

18 (h) The department shall adopt any regulations as are necessary
19 to ensure that the informing of beneficiaries of their health care
20 options is a part of the eligibility determination process.

21 *(i) This section shall remain in effect only until January 1, 2015,*
22 *and as of that date is repealed, unless a later enacted statute, that*
23 *is enacted before January 1, 2015, deletes or extends that date.*

24 SEC. 5. Section 15926.6 is added to the Welfare and
25 Institutions Code, to read:

26 15926.6. (a) An applicant or recipient of benefits under a state
27 health subsidy program shall be given the option, with his or her
28 informed consent, to have an application for renewal form
29 prepopulated or electronically verified in real time, or both, using
30 personal information from his or her own state health subsidy
31 program or other public benefits case file, a case file of that
32 individual's parent or child, or other electronic databases required
33 by the PPACA.

34 (1) An applicant or recipient who chooses to have an application
35 for renewal form prepopulated shall be given an opportunity, before
36 the application for renewal form is submitted to the entity
37 authorized to make eligibility determinations, to provide additional
38 eligibility information and to correct any information retrieved
39 from a database.

1 (2) An applicant or recipient who chooses to have an application
2 for renewal form electronically verified in real time shall be given
3 an opportunity, before or after a final eligibility determination is
4 made, to provide additional eligibility information and to correct
5 information retrieved from a database. An applicant or recipient
6 shall not be denied eligibility for any state health subsidy program
7 without being given a reasonable opportunity, of at least the kind
8 provided for under the Medi-Cal program for citizenship
9 documentation, to resolve discrepancies concerning any
10 information provided by a verifying entity. Applicants or recipients
11 shall receive the benefits for which they would otherwise qualify
12 pending this reasonable-opportunity period.

13 (b) Renewal procedures shall be coordinated across all state
14 health subsidy programs and among entities that accept and make
15 eligibility determinations so that all relevant information already
16 included in the individual's Medi-Cal or other public benefits case
17 file, his or her California Health Benefit Exchange case file, a case
18 file of the individual's parent or child, or other electronic databases
19 authorized for data sharing under the PPACA can be used to renew
20 benefits or transfer eligible recipients between programs without
21 a break in coverage and without requiring a recipient to provide
22 redundant information. Renewal procedures shall be as simple,
23 user-friendly, and accessible as possible, shall require recipients
24 to provide only the information that has changed, if any, and shall
25 use all available methods for reporting renewal information,
26 including, but not limited to, face-to-face, telephone, and online
27 renewal. Families shall be able to renew coverage at the same time
28 for all family members enrolled in any state health subsidy
29 program, including if family members are enrolled in more than
30 one state health subsidy program. A recipient shall be permitted
31 to update his or her eligibility information at any time.

32 SEC. 6. This act is an urgency statute necessary for the
33 immediate preservation of the public peace, health, or safety within
34 the meaning of Article IV of the Constitution and shall go into
35 immediate effect. The facts constituting the necessity are:

36 In order to implement provisions of the federal Patient Protection
37 and Affordable Care Act (Public Law 111-148), as amended by
38 the federal Health Care and Education Reconciliation Act of 2010

- 1 (Public Law 111-152), it is necessary that this act take effect
- 2 immediately.

O