AMENDED IN ASSEMBLY MAY 13, 2013

AMENDED IN ASSEMBLY MAY 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 50

Introduced by Assembly Member Pan

December 21, 2012

An act to amend Section 15926 of, to amend and repeal Sections 14016.5 and 14016.6 of, and to add Section 14011.66 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 amended, 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.

Existing law requires the California Health and Human Services Agency, in consultation with specified entities, to a establish standardized single, accessible application form and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements. Existing law authorizes the form to include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services pursuant to federal law.

~~This bill would instead require the form to include those questions effective January 1, 2015, and would additionally require the form to include questions that are voluntary for applicants to answer regarding sexual orientation and gender identity or expression.~~

This bill would authorize the form to also include questions that are voluntary for applicants to answer regarding sexual orientation and gender identity or expression. The bill would, effective January 1, 2015, require the form to include questions that are voluntary for applicants to answer regarding the demographic data categories specified.

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

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 14011.66 is added to the Welfare and Institutions Code, to read:

14011.66. The department shall establish a process in accordance with Section 1396a(a)(47)(B) of Title 42 of the United

States Code, effective January 1, 2014, to allow a hospital that is a participating provider under the state plan to elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for Medi-Cal under the state plan or under a federal waiver for purposes of providing the individual with medical assistance during the presumptive eligibility period.

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

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

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

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

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

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider

is a primary care provider or clinic contracting with any of the prepaid managed health care plans, pilot projects, or fee-for-service case management provider options available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

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

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

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

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

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

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

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or

who does not certify that he or she has an established relationship with a primary care provider or clinic, 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.

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

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

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

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

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

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

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

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

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

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

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

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

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

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

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic that it has been selected or assigned. The managed care plan, pilot project, or fee-for-service case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

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

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the presentation described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

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

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

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

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

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

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

(n) (1) Whenever a county welfare department notifies a public assistance recipient or Medi-Cal beneficiary that the recipient or beneficiary is losing Medi-Cal eligibility, the county shall include, in the notice to the recipient or beneficiary, notification that the

loss of eligibility shall also result in the recipient's or beneficiary's disenrollment from Medi-Cal managed health care or dental plans, if enrolled.

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

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

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

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

SEC. 3. Section 14016.6 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 4. Section 15926 of the Welfare and Institutions Code is amended to read:

15926. (a) The following definitions apply for purposes of this part:

(1) "Accessible" means in compliance with Section 11135 of the Government Code, Section 1557 of the PPACA, and regulations or guidance adopted pursuant to these statutes.

(2) "Limited-English-proficient" means not speaking English as one's primary language and having a limited ability to read, speak, write, or understand English.

(3) "State health subsidy programs" means the programs described in Section 1413(e) of the PPACA.

(b) An individual shall have the option to apply for state health subsidy programs in person, by mail, online, by telephone, or by other commonly available electronic means.

(c) (1) A single, accessible, standardized paper, electronic, and telephone application for state health subsidy programs shall be developed by the department in consultation with MRMIB and the board governing the Exchange as part of the stakeholder process described in subdivision (b) of Section 15925. The application shall be used by all entities authorized to make an eligibility determination for any of the state health subsidy programs and by their agents.

(2) The application shall be tested and operational by the date as required by the federal Secretary of Health and Human Services.

(3) The application form shall, to the extent not inconsistent with federal statutes, regulations, and guidance, satisfy all of the following criteria:

(A) The form shall include simple, user-friendly language and instructions.

(B) The form may not ask for information related to a nonapplicant that is not necessary to determine eligibility in the applicant's particular circumstances.

(C) The form may require only information necessary to support the eligibility and enrollment processes for state health subsidy programs.

(D) The form may be used for, but shall not be limited to, screening.

(E) The form may ask, or be used otherwise to identify, if the mother of an infant applicant under one year of age had coverage through a state health subsidy program for the infant's birth, for the purpose of automatically enrolling the infant into the applicable program without the family having to complete the application process for the infant.

(F) (i) Except as specified in clause (ii), the form may include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, sexual orientation, gender identity or expression, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

~~(F)~~

(ii) Effective January 1, 2015, the form shall include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, sexual orientation, gender identity or expression, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for state health subsidy programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures.

(e) The entity making the eligibility determination shall grant eligibility immediately whenever possible and with the consent of the applicant in accordance with the state and federal rules governing state health subsidy programs.

(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available electronic databases, an applicant shall be given the option, with his or her informed consent, to have the application form prepopulated. Before a prepopulated renewal form or, if available,

prepopulated application is submitted to the entity authorized to make eligibility determinations, the individual shall be given the opportunity to provide additional eligibility information and to correct any information retrieved from a database.

(2) All state health subsidy programs may accept self-attestation, instead of requiring an individual to produce a document, with respect to all information needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.

(3) An applicant or recipient shall have his or her information electronically verified in the manner required by the PPACA and implementing federal regulations and guidance.

(4) Before an eligibility determination is made, the individual shall be given the opportunity to provide additional eligibility information and to correct information.

(5) The eligibility of an applicant shall not be delayed or denied for any state health subsidy program unless the applicant is given a reasonable opportunity, of at least the kind provided for under the Medi-Cal program pursuant to Section 14007.5 and paragraph (7) of subdivision (e) of Section 14011.2, to resolve discrepancies concerning any information provided by a verifying entity.

(6) To the extent federal financial participation is available, an applicant shall be provided benefits in accordance with the rules of the state health subsidy program, as implemented in federal regulations and guidance, for which he or she otherwise qualifies until a determination is made that he or she is not eligible and all applicable notices have been provided. Nothing in this section shall be interpreted to grant presumptive eligibility if it is not otherwise required by state law, and, if so required, then only to the extent permitted by federal law.

(g) The eligibility, enrollment, and retention system shall offer an applicant and recipient assistance with his or her application or renewal for a state health subsidy program in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

(h) (1) During the processing of an application, renewal, or a transition due to a change in circumstances, an entity making eligibility determinations for a state health subsidy program shall ensure that an eligible applicant and recipient of state health

subsidy programs that meets all program eligibility requirements and complies with all necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual shall be informed about how to obtain information about the status of his or her application, renewal, or transfer to another program at any time, and the information shall be promptly provided when requested.

(2) The application or case of an individual screened as not eligible for Medi-Cal on the basis of Modified Adjusted Gross Income (MAGI) household income but who may be eligible on the basis of being 65 years of age or older, or on the basis of blindness or disability, shall be forwarded to the Medi-Cal program for an eligibility determination. During the period this application or case is processed for a non-MAGI Medi-Cal eligibility determination, if the applicant or recipient is otherwise eligible for a state health subsidy program, he or she shall be determined eligible for that program.

(3) Renewal procedures shall include all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, and online renewal.

(4) An applicant who is not eligible for a state health subsidy program for a reason other than income eligibility, or for any reason in the case of applicants and recipients residing in a county that offers a health coverage program for individuals with income above the maximum allowed for the Exchange premium tax credits, shall be referred to the county health coverage program in his or her county of residence.

(i) Notwithstanding subdivisions (e), (f), and (j), before an online applicant who appears to be eligible for the Exchange with a premium tax credit or reduction in cost sharing, or both, may be enrolled in the Exchange, both of the following shall occur:

(1) The applicant shall be informed of the overpayment penalties under the federal Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Public Law 112-9), if the individual's annual family income increases by a specified amount or more, calculated on the basis of the individual's current family size and current income, and that

penalties are avoided by prompt reporting of income increases throughout the year.

(2) The applicant shall be informed of the penalty for failure to have minimum essential health coverage.

(j) The department shall, in coordination with MRMIB and the Exchange board, streamline and coordinate all eligibility rules and requirements among state health subsidy programs using the least restrictive rules and requirements permitted by federal and state law. This process shall include the consideration of methodologies for determining income levels, assets, rules for household size, citizenship and immigration status, and self-attestation and verification requirements.

(k) (1) Forms and notices developed pursuant to this section shall be accessible and standardized, as appropriate, and shall comply with federal and state laws, regulations, and guidance prohibiting discrimination.

(2) Forms and notices developed pursuant to this section shall be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal law, and at a minimum, provided in the same threshold languages as required for Medi-Cal managed care plans.

(*l*) The department, the California Health and Human Services Agency, MRMIB, and the Exchange board shall establish a process for receiving and acting on stakeholder suggestions regarding the functionality of the eligibility systems supporting the Exchange, including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

(m) In designing and implementing the eligibility, enrollment, and retention system, the department, MRMIB, and the Exchange board shall ensure that all privacy and confidentiality rights under the PPACA and other federal and state laws are incorporated and followed, including responses to security breaches.

(n) Except as otherwise specified, this section shall be operative on and after January 1, 2014.

SEC. 5. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to implement provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), it is necessary that this act take effect immediately.

O