AMENDED IN SENATE SEPTEMBER 6, 2013

AMENDED IN SENATE JULY 2, 2013

AMENDED IN ASSEMBLY MAY 9, 2013

AMENDED IN ASSEMBLY APRIL 23, 2013

AMENDED IN ASSEMBLY APRIL 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1208

Introduced by Assembly Member Pan

February 22, 2013

An act to ~~add Chapter 3.5 (commencing with Section 24300) to Division 20 of the Health and Safety Code, relating to medical homes~~ *amend Section 15926 of the Welfare and Institutions Code, relating to health care coverage*.

LEGISLATIVE COUNSEL'S DIGEST

AB 1208, as amended, Pan. ~~Medical homes.~~ *Insurance affordability programs: application form.*

Existing law requires the California Health and Human Services Agency, in consultation with specified entities, to establish a single, standardized, accessible application form and related renewal procedures for insurance affordability 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. Chapter 3 of the First Extraordinary Session of the Statutes of 2013, to be effective on the 91st day after adjournment of that session, amended these provisions, among others, to implement various provisions of the federal Patient Protection and Affordable Care Act (PPACA).

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.

~~Existing law provides for the licensure and regulation of clinics and health facilities by the State Department of Public Health. Existing law also provides for the registration, certification, and licensure of various health care professionals and sets forth the scope of practice for these professionals.~~

~~This bill would establish the Patient Centered Medical Home Act of 2013 and would define a "medical home" and a "patient centered medical home" for purposes of the act to refer to a health care delivery model in which a patient establishes an ongoing relationship with a licensed health care provider, as specified. The bill would specify that it does not change the scope of practice of health care providers.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

SECTION 1. Section 15926 of the Welfare and Institutions Code, as amended by Section 26 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, 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) "Insurance affordability program" means a program that is one of the following:

(A) The Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(C) A program that makes available to qualified individuals coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with cost-sharing reductions established under Section 1402 of PPACA and any subsequent amendments to that act.

(b) An individual shall have the option to apply for insurance affordability 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 insurance affordability 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 insurance affordability programs and by their agents.

(2) The department may develop and require the use of supplemental forms to collect additional information needed to determine eligibility on a basis other than the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, as provided under Section 435.907(c) of Title 42 of the Code of Federal Regulations.

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

(4) 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 insurance affordability 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 an insurance affordability 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) ~~The~~ *(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.

(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.

(G) Until January 1, 2016, the department shall instruct counties to not reject an application that was in existence prior to January 1, 2014, but to accept the application and request any additional information needed from the applicant in order to complete the eligibility determination process. The department shall work with counties and consumer advocates to develop the supplemental questions.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for insurance affordability programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures. Nothing in this section shall preclude the use of a joint application, developed by the department and the State Department of Social Services, that allows for an application to be made for multiple programs, including, but not limited to, CalWORKs, CalFresh, and insurance affordability programs.

(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 insurance affordability 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 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 insurance affordability programs may accept self-attestation, instead of requiring an individual to produce a document, for age, date of birth, family size, household income, state residence, pregnancy, and any other applicable criteria 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 and state law.

(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 beyond the timeliness standards as provided in Section 435.912 of Title 42 of the Code of Federal Regulations or denied for any insurance affordability 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 insurance affordability 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 an insurance affordability program in person, over the telephone, by mail, online, or through other commonly available electronic means 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 an insurance affordability program shall ensure that an eligible applicant and recipient of insurance affordability 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 an insurance affordability 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, mail, and online renewal or renewal through other commonly available electronic means.

(4) An applicant who is not eligible for an insurance affordability 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 insurance affordability 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 January 1, 2014.

~~SECTION 1. Chapter 3.5 (commencing with Section 24300) is added to Division 20 of the Health and Safety Code, to read:~~

~~CHAPTER 3.5. PATIENT CENTERED MEDICAL HOME ACT OF 2013~~

~~24300. This chapter shall be known, and may be cited, as the Patient Centered Medical Home Act of 2013.~~

~~24301. (a) "Medical home" and "patient centered medical home" mean a health care delivery model in which a patient establishes an ongoing relationship with a personal primary care physician or other licensed health care provider acting within the scope of his or her practice. The personal provider works in a physician-led practice team to provide comprehensive, accessible,~~

~~and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost-effective manner.~~

~~(b) A medical home shall stress a team approach to providing comprehensive health care that fosters a partnership among the patient, the licensed health care provider acting within his or her scope of practice, other health care professionals, and, if appropriate, the patient's family or the patient's representative, upon the consent of the patient.~~

~~24302. Unless otherwise provided by statute, a medical home shall include all of the following characteristics:~~

~~(a) Individual patients shall have an ongoing relationship with a physician and surgeon or other licensed health care provider acting within his or her scope of practice, who is trained to provide first contact and continuous and comprehensive care, or, if appropriate, provide referrals to health care professionals that provide continuous and comprehensive care.~~

~~(b) A provider, working in concert with a multidisciplinary team of individuals at the practice level, shall take responsibility for the ongoing health care of patients, including appropriately arranging health care by other qualified health care professionals and making appropriate referrals.~~

~~(c) Care shall be coordinated and integrated across all elements of the complex health care system, including mental health and substance use disorder care, and the patient's community. Care shall be facilitated by health information technology, such as electronic medical records, electronic patient portals, health information exchanges, and other means to ensure that patients receive the indicated care when and where they need and want this care in a culturally and linguistically appropriate manner.~~

~~(d) The medical home payment structure shall be designed to reward the provision of the right care in the right setting, and shall discourage the delivery of too much or too little care. The payment structure shall encourage appropriate management of complex medical cases, increased access to care, the measurement of patient outcomes, continuous improvement of care quality, and comprehensive integration and coordination across all stages and settings of a patient's care.~~

~~(e) All of the following quality and safety components shall be incorporated into the medical home:~~

~~(1) Advocacy for patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family or representative.~~

~~(2) Evidence-based medicine and clinical decision support tools guide decisionmaking.~~

~~(3) The licensed health care providers in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.~~

~~(4) Active patient participation in decisionmaking. Feedback is sought to ensure that the patient's expectations are being met.~~

~~(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.~~

~~(6) Patients and families or representatives participate in quality improvement activities at the practice level.~~

~~(7) Patients are provided with enhanced access to health care.~~

~~24303. Nothing in this chapter shall be construed to do any of the following:~~

~~(a) Permit a medical home to engage in or otherwise aid and abet in the unlicensed practice of medicine, either directly or indirectly.~~

~~(b) Change the scope of practice of physicians and surgeons, nurse practitioners, or other health care providers.~~

~~(c) Affect the ability of a nurse to operate under standardized procedures pursuant to Section 2725 of the Business and Professions Code.~~

~~(d) Apply to the Low Income Health Program developed pursuant to Part 3.6 (commencing with Section 15909) of Division 9 of the Welfare and Institutions Code, including the program's provider network and service delivery system, or to activities conducted as part of a demonstration project developed pursuant to Section 14180 of the Welfare and Institutions Code.~~

~~(e) Prevent or limit participation in activities authorized by Sections 2703, 3024, and 3502 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), if the participation is consistent with state law pertaining to scope of practice.~~

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