SENATE BILL No. 986

Introduced by Senator Hernandez

February 11, 2014

An act to amend Section 14182 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 986, as introduced, Hernandez. Medi-Cal: managed care: seniors and persons with disabilities.

Existing law provides for the Medi-Cal program, 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. One of the methods by which these services are provided is pursuant to contracts with various types of managed care health plans. Existing law authorizes the department, in furtherance of a specified waiver or demonstration project, to require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new or existing managed care health plans. Existing law requires the department, in exercising its authority pursuant to these provisions, to, among other things, ensure that managed care health plans participating in the demonstration project provide access to out-of-network providers for new individual members and comply with continuity of care requirements, as specified.

This bill would instead require the department to ensure that the managed care health plans participating in the demonstration project provide timely access to out-of-network providers for new individual members and fully comply with the continuity of care requirements.

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

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

SECTION 1. Section 14182 of the Welfare and Institutions Code is amended to read:

14182. (a) (1) In furtherance of the waiver or demonstration project developed pursuant to Section 14180, the department may require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new or existing managed care health plans. To the extent that enrollment is required by the department, an enrollee's access to fee-for-service Medi-Cal shall not be terminated until the enrollee has been assigned to a managed care health plan.

(2) For purposes of this section:

(A) "Other health coverage" means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program, or health coverage under contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(B) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200).

(b) In exercising its authority pursuant to subdivision (a), the department shall do all of the following:

(1) Assess and ensure the readiness of the managed care health plans to address the unique needs of seniors or persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure the managed care health plans provide access to providers that comply with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(3) Develop and implement an outreach and education program for seniors and persons with disabilities, not currently enrolled in Medi-Cal managed care, to inform them of their enrollment options and rights under the demonstration project. Contingent upon

available private or public dollars other than moneys from the General Fund, the department or its designated agent for enrollment and outreach may partner or contract with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting seniors and persons with disabilities in understanding their health care coverage options. Contracts entered into or amended pursuant to this paragraph shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and any implementing regulations or policy directives.

(4) At least three months prior to enrollment, inform beneficiaries who are seniors or persons with disabilities, through a notice written at no more than a sixth grade reading level, about the forthcoming changes to their delivery of care, including, at a minimum, how their system of care will change, when the changes will occur, and who they can contact for assistance with choosing a delivery system or with problems they encounter. In developing this notice, the department shall consult with consumer representatives and other stakeholders.

(5) Implement an appropriate cultural awareness and sensitivity training program regarding serving seniors and persons with disabilities for managed care health plans and plan providers and staff in the Medi-Cal Managed Care Division of the department.

(6) Establish a process for assigning enrollees into an organized delivery system for beneficiaries who do not make an affirmative selection of a managed care health plan. The department shall develop this process in consultation with stakeholders and in a manner consistent with the waiver or demonstration project developed pursuant to Section 14180. The department shall base plan assignment on an enrollee’s existing or recent utilization of providers, to the extent possible. If the department is unable to make an assignment based on the enrollee’s affirmative selection or utilization history, the department shall base plan assignment on factors, including, but not limited to, plan quality and the inclusion of local health care safety net system providers in the plan’s provider network.

(7) Review and approve the mechanism or algorithm that has been developed by the managed care health plan, in consultation with their stakeholders and consumers, to identify, within the earliest possible timeframe, persons with higher risk and more

complex health care needs pursuant to paragraph (11) of subdivision (c).

(8) Provide managed care health plans with historical utilization data for beneficiaries upon enrollment in a managed care health plan so that the plans participating in the demonstration project are better able to assist beneficiaries and prioritize assessment and care planning.

(9) Develop and provide managed care health plans participating in the demonstration project with a facility site review tool for use in assessing the physical accessibility of providers, including specialists and ancillary service providers that provide care to a high volume of seniors and persons with disabilities, at a clinic or provider site, to ensure that there are sufficient physically accessible providers. Every managed care health plan participating in the demonstration project shall make the results of the facility site review tool publicly available on their Internet Web site and shall regularly update the results to the department's satisfaction.

(10) Develop a process to enforce legal sanctions, including, but not limited to, financial penalties, withholding of Medi-Cal payments, enrollment termination, and contract termination, in order to sanction any managed care health plan in the demonstration project that consistently or repeatedly fails to meet performance standards provided in statute or contract.

(11) Ensure that managed care health plans provide a mechanism for enrollees to request a specialist or clinic as a primary care provider. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollee.

(12) Ensure that managed care health plans participating in the demonstration project are able to provide communication access to seniors and persons with disabilities in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language, or written translations and oral interpreters, including for those who are limited English-proficient, or non-English speaking, and that all managed care health plans are in compliance with applicable cultural and linguistic requirements.

(13) Ensure that managed care health plans participating in the demonstration project provide *timely* access to out-of-network providers for new individual members enrolled under this section who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

(14) Ensure that managed care health plans participating in the demonstration project *fully* comply with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

(15) Ensure that the medical exemption criteria applied in counties operating under Chapter 4.1 (commencing with Section 53800) or Chapter 4.5 (commencing with Section 53900) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations are applied to seniors and persons with disabilities served under this section.

(16) Ensure that managed care health plans participating in the demonstration project take into account the behavioral health needs of enrollees and include behavioral health services as part of the enrollee's care management plan when appropriate.

(17) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set (HEDIS) or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance (NCQA) Structure and Process measures, or both.

(18) Conduct medical audit reviews of participating managed care health plans that include elements specifically related to the care of seniors and persons with disabilities. These medical audits shall include, but not be limited to, evaluation of the delivery model's policies and procedures, performance in utilization management, continuity of care, availability and accessibility, member rights, and quality management.

(19) Conduct financial audit reviews to ensure that a financial statement audit is performed on managed care health plans annually

pursuant to the Generally Accepted Auditing Standards, and conduct other risk-based audits for the purpose of detecting fraud and irregular transactions.

(20) Ensure that managed care health plans maintain a dedicated liaison to coordinate with the department, affected providers, and new individual members for all of the following purposes:

(A) To ensure a mechanism for new members to obtain continuity of care as described in paragraph (13).

(B) To receive notice, including that a new member has been denied a medical exemption as described in paragraph (15), which is required to include the name or names of the requesting provider, and ensure that the provider's ability to treat the member is continued as described in paragraphs (11) and (13), if applicable, or, if not applicable, ensure the member is immediately referred to a qualified provider or specialty care center.

(C) To assist new members in maintaining an ongoing relationship with a specialist or specialty care center when the specialist is contracting with the plan and the assigned primary care provider has approved a standing referral pursuant to Section 1374.16 of the Health and Safety Code.

(21) Ensure that written notice is provided to the beneficiary and the requesting provider if a request for exemption from plan enrollment is denied. The notice shall set out with specificity the reasons for the denial or failure to unconditionally approve the request for exemption from plan enrollment. The notice shall inform the beneficiary and the provider of the right to appeal the decision, how to appeal the decision, and if the decision is not appealed, that the beneficiary shall enroll in a Medi-Cal plan and how that enrollment shall occur. The notice shall also include information of the possibility of continued access to an out-of-network provider pursuant to paragraph (13). A beneficiary who has not been enrolled in a plan shall remain in fee-for-service Medi-Cal if a request for an exemption from plan enrollment or appeal is submitted, until the final resolution. The department shall also require the plans to ensure that these beneficiaries receive continuity of care.

(22) Develop a process to track a beneficiary who has been denied a request for exemption from plan enrollment and to notify the plan, if applicable, of the denial, including information identifying the provider. Notwithstanding paragraph (12) of

subdivision (c), the plan shall immediately refer the beneficiary for a risk assessment survey and an individual care plan shall be developed within 10 days, including authorization for 30 days of continuity of prescription drugs.

(c) Prior to exercising its authority under this section and Section 14180, the department shall ensure that each managed care health plan participating in the demonstration project is able to do all of the following:

(1) Comply with the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area. Managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and Internet Web site.

(3) Assess the health care needs of beneficiaries who are seniors or persons with disabilities and coordinate their care across all settings, including coordination of necessary services within and, where necessary, outside of the plan's provider network.

(4) Ensure that the provider network and informational materials meet the linguistic and other special needs of seniors and persons with disabilities, including providing information in an understandable manner in plain language, maintaining toll-free telephone lines, and offering member or ombudsperson services.

(5) Provide clear, timely, and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits. Each managed care health plan participating in the demonstration project shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(6) Solicit stakeholder and member participation in advisory groups for the planning and development activities related to the provision of services for seniors and persons with disabilities.

(7) Contract with safety net and traditional providers as defined in subdivisions (hh) and (jj) of Section 53810, of Title 22 of the

California Code of Regulations, to ensure access to care and services. The managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(8) Inform seniors and persons with disabilities of procedures for obtaining transportation services to service sites that are offered by the plan or are available through the Medi-Cal program.

(9) Monitor the quality and appropriateness of care for children with special health care needs, including children eligible for, or enrolled in, the California Children's Services Program, and seniors and persons with disabilities.

(10) Maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(11) At the time of enrollment apply the risk stratification mechanism or algorithm described in paragraph (7) of subdivision (b) approved by the department to determine the health risk level of beneficiaries.

(12) (A) Managed care health plans shall assess an enrollee's current health risk by administering a risk assessment survey tool approved by the department. This risk assessment survey shall be performed within the following timeframes:

(i) Within 45 days of plan enrollment for individuals determined to be at higher risk pursuant to paragraph (11).

(ii) Within 105 days of plan enrollment for individuals determined to be at lower risk pursuant to paragraph (11).

(B) Based on the results of the current health risk assessment, managed care health plans shall develop individual care plans for higher risk beneficiaries that shall include the following minimum components:

(i) Identification of medical care needs, including primary care, specialty care, durable medical equipment, medications, and other needs with a plan for care coordination as needed.

(ii) Identification of needs and referral to appropriate community resources and other agencies as needed for services outside the scope of responsibility of the managed care health plan.

(iii) Appropriate involvement of caregivers.

(iv) Determination of timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level.

(13) (A) Establish medical homes to which enrollees are assigned that include, at a minimum, all of the following elements, which shall be considered in the provider contracting process:

(i) A primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions.

(ii) Care management and care coordination for the beneficiary across the health care system including transitions among levels of care.

(iii) Provision of referrals to qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the managed care health plan.

(iv) Use of clinical data to identify beneficiaries at the care site with chronic illness or other significant health issues.

(v) Timely preventive, acute, and chronic illness treatment in the appropriate setting.

(vi) Use of clinical guidelines or other evidence-based medicine when applicable for treatment of beneficiaries' health care issues or timing of clinical preventive services.

(B) In implementing this section, and the Special Terms and Conditions of the demonstration project, the department may alter the medical home elements described in this paragraph as necessary to secure the increased federal financial participation associated with the provision of medical assistance in conjunction with a health home, as made available under 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), and codified in Section 1945 of Title XIX of the federal Social Security Act. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to alter medical home elements under this section at least five days in advance of taking this action.

(14) Perform, at a minimum, the following care management and care coordination functions and activities for enrollees who are seniors or persons with disabilities:

(A) Assessment of each new enrollee's risk level and health needs shall be conducted through a standardized risk assessment

survey by means such as telephonic, Web-based, or in-person communication or by other means as determined by the department.

(B) Facilitation of timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including referrals to address any physical or cognitive barriers to access.

(C) Active referral to community resources or other agencies for needed services or items outside the managed care health plans responsibilities.

(D) Facilitating communication among the beneficiaries' health care providers, including mental health and substance abuse providers when appropriate.

(E) Other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(d) Except in a county where Medi-Cal services are provided by a county-organized health system, and notwithstanding any other provision of law, in any county in which fewer than two existing managed care health plans contract with the department to provide Medi-Cal services under this chapter, the department may contract with additional managed care health plans to provide Medi-Cal services for seniors and persons with disabilities and other Medi-Cal beneficiaries.

(e) Beneficiaries enrolled in managed care health plans pursuant to this section shall have the choice to continue an established patient-provider relationship in a managed care health plan participating in the demonstration project if his or her treating provider is a primary care provider or clinic contracting with the managed care health plan and agrees to continue to treat that beneficiary.

(f) The department may contract with existing managed care health plans to operate under the demonstration project to provide or arrange for services under this section. Notwithstanding any other provision of law, the department may enter into the contract without the need for a competitive bid process or other contract proposal process, provided the managed care health plan provides written documentation that it meets all qualifications and requirements of this section.

(g) This section shall be implemented only to the extent that federal financial participation is available.

(h) (1) The development of capitation rates for managed care health plan contracts shall include the analysis of data specific to the seniors and persons with disabilities population. For the purposes of developing capitation rates for payments to managed care health plans, the director may require managed care health plans, including existing managed care health plans, to submit financial and utilization data in a form, time, and substance as deemed necessary by the department.

(2) (A) Notwithstanding Section 14301, the department may incorporate, on a one-time basis for a three-year period, a risk-sharing mechanism in a contract with the local initiative health plan in the county with the highest normalized fee-for-service risk score over the normalized managed care risk score listed in Table 1.0 of the Medi-Cal Acuity Study Seniors and Persons with Disabilities (SPD) report written by Mercer Government Human Services Consulting and dated September 28, 2010, if the local initiative health plan meets the requirements of subparagraph (B). The Legislature finds and declares that this risk-sharing mechanism will limit the risk of beneficial or adverse effects associated with a contract to furnish services pursuant to this section on an at-risk basis.

(B) The local initiative health plan shall pay the nonfederal share of all costs associated with the development, implementation, and monitoring of the risk-sharing mechanism established pursuant to subparagraph (A) by means of intergovernmental transfers. The nonfederal share includes the state costs of staffing, state contractors, or administrative costs directly attributable to implementing subparagraph (A).

(C) This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.

(i) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591), may select a PACE plan if one is available in that county.

(j) Persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary care case management (PCCM) plan in operation on that date, may select that PCCM plan or a successor health care plan that is licensed pursuant to the

Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) to provide services within the same geographic area that the PCCM plan served on January 1, 2010.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(*l*) Consistent with state law that exempts Medi-Cal managed care contracts from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code, and in order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process is necessary for contracts entered into or amended pursuant to this section. The contracts and amendments entered into or amended pursuant to this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and the requirements of State Administrative Management Manual Memo 03-10. The department shall make the terms of a contract available to the public within 30 days of the contract's effective date.

(m) In the event of a conflict between the Special Terms and Conditions of the approved demonstration project, including any attachment thereto, and any provision of this part, the Special Terms and Conditions shall control. If the department identifies a specific provision of this article that conflicts with a term or condition of the approved waiver or demonstration project, or an attachment thereto, the term or condition shall control, and the department shall so notify the appropriate fiscal and policy committees of the Legislature within 15 business days.

(n) In the event of a conflict between the provisions of this article and any other provision of this part, the provisions of this article shall control.

(o) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) not in conflict with this article or with the terms and conditions of the demonstration project shall apply to this section.

(p) To the extent that the director utilizes state plan amendments or waivers to accomplish the purposes of this article in addition to waivers granted under the demonstration project, the terms of the state plan amendments or waivers shall control in the event of a conflict with any provision of this part.

(q) (1) Enrollment of seniors and persons with disabilities into a managed care health plan under this section shall be accomplished using a phased-in process to be determined by the department and shall not commence until necessary federal approvals have been acquired or until June 1, 2011, whichever is later.

(2) Notwithstanding paragraph (1), and at the director's discretion, enrollment in Los Angeles County of seniors and persons with disabilities may be phased-in over a 12-month period using a geographic region method that is proposed by Los Angeles County subject to approval by the department.

(r) A managed care health plan established pursuant to this section, or under the Special Terms and Conditions of the demonstration project pursuant to Section 14180, shall be subject to, and comply with, the requirement for submission of encounter data specified in Section 14182.1.

(s) (1) Commencing January 1, 2011, and until January 1, 2014, the department shall provide the fiscal and policy committees of the Legislature with semiannual updates regarding core activities for the enrollment of seniors and persons with disabilities into managed care health plans pursuant to the pilot program. The semiannual updates shall include key milestones, progress toward the objectives of the pilot program, relevant or necessary changes to the program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and other key activities related to the mandatory enrollment of seniors and persons with disabilities into managed care health plans. The department shall also include

updates on the transition of individuals into managed care health plans, the health outcomes of enrollees, the care management and coordination process, and other information concerning the success or overall status of the pilot program.

(2) (A) The requirement for submitting a report imposed under paragraph (1) is inoperative on January 1, 2015, pursuant to Section 10231.5 of the Government Code.

(B) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(t) The department, in collaboration with the State Department of Social Services and county welfare departments, shall monitor the utilization and caseload of the In-Home Supportive Services (IHSS) program before and during the implementation of the pilot program. This information shall be monitored in order to identify the impact of the pilot program on the IHSS program for the affected population.

(u) Services under Section 14132.95 or 14132.952, or Article 7 (commencing with Section 12300) of Chapter 3 that are provided to individuals assigned to managed care health plans under this section shall be provided through direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium, in accordance with and subject to the requirements of Section 12302 or 12301.6, as applicable.

(v) The department shall, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans.

(w) The department shall suspend new enrollment of seniors and persons with disabilities into a managed care health plan if it determines that the managed care health plan does not have sufficient primary or specialty providers to meet the needs of their enrollees.

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