

Senate Bill No. 835

CHAPTER 859

An act to amend Sections 14016.5, 14088.05, 14088.22, 14089, 14301, 14304, and 14408 of, and to add Sections 14087.305, 14088.23, and 14464 to, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor October 12, 1995. Filed
with Secretary of State October 13, 1995.]

LEGISLATIVE COUNSEL'S DIGEST

SB 835, M. Thompson. Medi-Cal: health care providers.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law also requires a Medi-Cal beneficiary or applicant to indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either obtaining benefits by receiving a monthly Medi-Cal card, which may be used to obtain services from individual providers, or by enrolling in a prepaid managed care health 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.

This bill would also require any beneficiary or applicant selecting a managed health care plan, pilot project, or fee-for-service case management provider beneficiary to indicate, in writing, his or her choice of primary care physician contracting with the selected managed care plan, pilot project, or fee-for-service case management provider and would provide for the assignment of the beneficiary or applicant if he or she does not elect to make a choice in specified areas.

The bill would also revise procedures for the reimbursement of health care plan providers and for the termination of contracts with providers and the alternative penalties that may be imposed as sanctions for failure to meet standards adopted by the department.

Existing law generally prohibits door-to-door solicitation of Medi-Cal enrollees for or by prepaid health plans on and after January 1, 1994, with specified exceptions.

This bill would revise the commencement of that prohibition to January 1, 1996, would include direct marketing with the scope of the prohibition, and would impose a state-mandated local program by making a violation of the prohibition a misdemeanor.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state.

Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. 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 or aid to families with dependent children (AFDC) 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, and telephone number of each primary care provider, by specialty, or clinic participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option. The name, address, and telephone number of each specialist participating in each prepaid managed care health plan, pilot project, or fee-for-service case management provider option shall be made available by either contacting the health care options contractor or the prepaid managed care health 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 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 projects, 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 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 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 or 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 managed care 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 managed care 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, 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 than 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 which 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, means 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) 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.

SEC. 2. Section 14087.305 is added to the Welfare and Institutions Code, to read:

14087.305. (a) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or Aid to Families with Dependent Children (AFDC) applicant or beneficiary shall be informed of the managed care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(b) The managed care options information described in subdivision (a) shall include the following elements:

(1) Each beneficiary or eligible applicant shall be provided with the name, address, and telephone number of each primary care provider, by specialty, or clinic, participating in each prepaid health plan option. The name, address, and telephone number of each specialist participating in each prepaid health plan shall be made available by contacting the health care options contractor or the prepaid health plan.

(2) 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 contracting with any of the prepaid health plan options available and has available capacity and agrees to continue to treat that beneficiary or applicant.

(3) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a prepaid health plan.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible for Medi-Cal, the beneficiary shall indicate his or her choice, in writing, from among the available prepaid health plans in the region and his or her choice of primary care provider contracting with the selected prepaid health plan.

(d) At the time the beneficiary or eligible applicant selects a prepaid health plan, 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 health plan.

(e) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3, and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or AFDC beneficiary who does not make a choice of managed care plans, shall be assigned to and enrolled in an appropriate Medi-Cal prepaid health plan providing service within the area in which the beneficiary resides.

(f) 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 prepaid health plan 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.

(g) Any Medi-Cal or AFDC beneficiary dissatisfied with the primary care provider or prepaid health plan shall be allowed to select or be assigned to another primary care provider within the same prepaid health plan. In addition, the beneficiary shall be allowed to select or be assigned to another prepaid health plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides, in accordance with Section 1903 (m) (2) (F) (ii) of the Social Security Act.

(h) The department or its contractor shall notify a prepaid health plan when it has been selected by or assigned to a beneficiary. The prepaid health plan that has been selected by or assigned to a beneficiary shall notify the primary care provider that has been selected or assigned. The prepaid health plan shall also notify the beneficiary of the prepaid health plan and primary care provider selected or assigned.

(i) (1) The managed health 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, 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 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.

(j) To the extent possible, the arrangements for carrying out subdivision (e) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating prepaid health plans, or managed care plans.

(k) 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.

SEC. 3. Section 14088.05 of the Welfare and Institutions Code is amended to read:

14088.05. For purposes of this article, "primary care case management plan" means a primary care provider or other entity who has contracted with the department pursuant to this article.

SEC. 4. Section 14088.22 of the Welfare and Institutions Code is amended to read:

14088.22. Sections 14408, 14409, 14410, and 14411 shall apply to primary care case management plans.

SEC. 5. Section 14088.23 is added to the Welfare and Institutions Code, to read:

14088.23. (a) The department may apply one or more of the following sanctions against any contractor for failure to comply with the requirements of this article, regulations adopted by the department, the contract between the contractor and the department, or for other good cause shown. Good cause includes, but is not necessarily limited to, three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care, as defined by the department in accordance with this section, identified in the medical audits conducted by the department:

- (1) Terminate the contract.
- (2) Suspend enrollment and marketing activities.
- (3) Require the contractor to suspend or terminate personnel of the contractor or to terminate participation by subcontractors specified by the department.
- (4) Impose civil penalties not to exceed ten thousand dollars (\$10,000) per violation pursuant to regulations adopted by the director. Unless imposed in error, penalties shall not be returned to the plan.
- (5) Take other appropriate action as determined necessary by the department.

(b) The department shall give the contractor and any other persons who may be directly interested not less than 30 days' notice



of its intention to impose any of the sanctions authorized by this section.

(c) The notice required by subdivision (b) shall be written, and shall specify each requirement that has not been met, the proposed effective date of the sanction or sanctions, and the amount and duration of each proposed sanction.

(d) (1) Within five working days after the receipt of the written notice required by subdivision (b), the contractor may submit notice of its intent to comply with the requirements specified in the written notice.

(2) If the contractor submits the notice of intent authorized by paragraph (1), the department shall allow the contractor to demonstrate its compliance with the requirements specified in the department's written notice, commencing within 30 calendar days from the date of the submission of the notice of intent to comply by the contractor. Within 15 days following the completion of the 30-day compliance correction period, the department shall review the corrective actions taken by the contractor and, if appropriate, approve those actions.

(3) If a contractor subject to notice to apply sanctions under subdivision (b) does not demonstrate appropriate corrective compliance within the 30-day corrective action period or does not submit a notice of intent to comply with the requirements specified in the notice required by subdivision (b), the department shall notify the contractor, in writing, of the effective date and terms of the sanction or sanctions applied pursuant to this section.

(4) A contractor may appeal sanctions applied pursuant to this section to the department within 15 working days after the notice of the effective date of the sanctions has been provided pursuant to paragraph (3), setting forth relevant facts and arguments. The department shall grant or deny the appeal within 30 calendar days after receiving the appeal.

(e) The department may collect civil penalties imposed pursuant to this section by withholding the amount of the penalty from capitation payments owed by the department to the contractor.

SEC. 6. Section 14089 of the Welfare and Institutions Code is amended to read:

14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed care arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and



university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.

(b) The negotiator may seek proposals and then shall contract based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:

(1) Certification, where legally required, by the Commissioner of Corporations and the Insurance Commissioner.

(2) Compliance with all of the following:

(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.

(B) The health plan shall meet any standards established by the department for the implementation of this article.

(C) The health plan receives the approval of the department to participate in the pilot project under this article.

(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid or postpayment basis.

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries 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).

(2) The cost of each program established under this section shall not exceed the total amount which the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(d) The department shall enter into contracts pursuant to this article, and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

(e) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. Enrollment shall be for a minimum of six months. Contracts entered into pursuant to this article shall be for at least one but no more than three years. The director shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides.



(2) No later than 30 days following the date a Medi-Cal or AFDC recipient is informed of the health care options described in paragraph (1) of subdivision (e), the recipient shall indicate his or her choice in writing of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan.

(3) The health care options information described in paragraph (1) of subdivision (e) shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided with the name, address, and telephone number of each primary care provider, by specialty, or clinic participating in each health care plan. The name, address, and telephone number of each specialist participating in each health care plan shall be made available by contacting the health care options contractor or the health care plan.

(B) 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 contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.

(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider contracting with the selected health care plan.

(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or AFDC beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.

(6) 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 health care plan 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.

(7) Any Medi-Cal or AFDC beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she



resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.

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

(f) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.

(g) The negotiator and the department shall establish pilot projects to test the cost-effectiveness of delivering benefits as defined in subdivisions (a) through (f).

(h) The California Medical Assistance Commission shall evaluate the cost-effectiveness of these pilot projects after one year of implementation. Pursuant to this evaluation the commission may either terminate or retain the existing pilot projects.

(i) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.

(j) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. These contracts shall have no force and effect unless approved by the Department of Finance.

SEC. 7. Section 14301 of the Welfare and Institutions Code is amended to read:

14301. (a) The department shall determine, by actuarial methods, prospective per capita rates of payment for services provided under this chapter for Medi-Cal beneficiaries enrolled in a prepaid health plan. The rates of payment shall be determined annually, shall be effective no later than either the first day of July each year, or another date chosen by the department, and shall not exceed the total per capita amount (including cost of administration) which the department estimates (with appropriate adjustments to provide actuarial equivalence) would be payable for all services and requirements covered under the prepaid health plan contract if all such services and requirements were to be furnished to Medi-Cal



beneficiaries under the fee-for-service Medi-Cal program provided for by Chapter 7 (commencing with Section 14000).

In the event that there is any delay in the payment of the new annual rates determined pursuant to this subdivision, continued payment to the prepaid health plan of the rate in effect at the time the delay occurred shall be interim payment only, and shall be subject to increase or decrease, as the case may be, to the level of the new annual rates effective as of either the first day of July or the date chosen by the department.

Notwithstanding the foregoing provision, in the event that a contract amendment providing for the new annual rates has been executed by the department and a prepaid health plan, but has not yet received the approval of all required control agencies and departments by the end of the first month following the effective date of the new rate, payment of the new annual rates shall commence no later than the first day of the second month following the effective date of the new rate. Contract amendments providing for the new annual rates shall provide that the prepaid health plan contractor agrees that by accepting payment of the new annual rates prior to final approval, such contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rates differ from the rates set forth in such amendments, any underpayment by the state shall be paid by the department to the prepaid health plan within 30 days after final approval of such rates. Any overpayment by the state shall be recaptured by the state withholding the amount due from the prepaid health plan's next capitation check. If the amount to be withheld from subsequent capitation checks exceeds 25 percent of the appropriate capitation payment for that month, amounts up to 25 percent shall be withheld from each successive monthly capitation payment until such deficiencies are recovered by the state.

The contract shall provide the specific per capita rates, to be determined by sound actuarial methods on the basis of age, sex, and aid categories, which the state shall pay the prepaid health plan each month for each beneficiary enrolled in the prepaid health plan, a detailed description of the specific actuarial method or methods and assumptions used in determining per capita rates, and a summary of the data base, including costs and inflation assumptions and utilization rates, which was used to determine per capita rates. In addition, the director shall engage and rely upon the services of an actuary or consulting actuary in determining prospective per capita rates.

(b) Any prepaid health plan with an operating experience and scale of operation deemed by the department to be insufficient to justify the application of an actuarially determined per capita rate, shall be reimbursed on a cost basis up to the fee-for-service maximum for services provided until such time as the director determines that



a per capita method is reasonable, but not to exceed a period of one year. For purposes of this section, costs shall be net of intercompany profits in those circumstances where any of the following persons have a substantial financial interest, as defined by Section 14478, in any vendor to the prepaid health plan or any vendor to a subcontractor of the plan:

(1) Any person also having a substantial financial interest in the plan.

(2) Any director, officer, partner, trustee or employee of the plan.

(3) Any member of the immediate family of any person designated in paragraph (1) or (2).

(c) The obligations of a prepaid health plan shall be changed only by contract or contract amendment. Any such change may be made during a contract term or at the time of contract renewal, where there is a change in obligations required by federal or state law or regulation, or required by a change in the interpretation or implementation of any such law or regulation. If any such change in obligations occurs which affects the cost to a prepaid health plan of performing under the terms of its contract, then the per capita rates under the contract may be redetermined in the manner provided by subdivision (a) to reflect such change. During such period of time as is required to redetermine the per capita rates, payment to a prepaid health plan of the per capita rates in effect at the time such change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which such change is effective.

(d) The obligations of a prepaid health plan shall be changed only by contract or contract amendment wherein payment for the changes, whether payment results in an increase or decrease in the prior per capita rates paid to a prepaid health plan, shall be determined in accordance with this section and paid to affected prepaid health plans.

(e) Nothing contained in this section shall be construed as removing from a prepaid health plan the risk of beneficial or adverse effects, including inflation, which normally result from contracting to furnish health services.

(f) Per capita rates of payment for services provided to Medi-Cal beneficiaries enrolled in prepaid health plans or Medi-Cal managed care plans contracting in areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 or contracting under Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96, 14089, and 14089.05 shall be paid by the state effective the date a beneficiary's enrollment takes effect. A primary care provider or clinic contracting with a prepaid health plan or a Medi-Cal managed care plan on a capitation basis and whose assignment to or selection by a beneficiary has been confirmed by the plan shall be paid capitation payments effective the date of the



beneficiary's enrollment. However, a primary care provider whose assignment to or selection by a beneficiary was not confirmed by the plan on the date of the beneficiary's enrollment, but is later confirmed by the plan, shall be paid capitation payments effective no later than 30 days after the beneficiary's enrollment. The prepaid health plan or Medi-Cal managed care plan shall be financially responsible for all Medi-Cal services covered under the contract with the department for any newly enrolled beneficiary until that beneficiary has a confirmed assignment to a primary care provider or clinic. This subdivision shall not apply when a beneficiary requests a change in primary care provider after initial selection or assignment.

SEC. 8. Section 14304 of the Welfare and Institutions Code is amended to read:

14304. (a) The director shall terminate a contract with a prepaid health plan or a Medi-Cal managed health care plan if he or she finds that the standards prescribed in this chapter, the regulations, or the contract are not being complied with, that claims accrued or to accrue have not or will not be recompensed, or for other good cause shown. Good cause includes, but is not necessarily limited to, three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care, as defined by the department in accordance with this section, identified in the medical audits conducted by the department. Except in the event that the director determines there is an immediate threat to the health of Medi-Cal beneficiaries enrolled in the plan, the Office of Administrative Hearings, at the request of the plan, shall hold a public hearing to commence 30 days after notice of intent to terminate the contract has been received by the plan. The department shall present evidence at the hearing showing good cause for the termination. The Office of Administrative Hearings shall provide its written recommendation to the department on the termination of the contract within 30 days after conclusion of the hearing. Reasonable notice of the hearing shall be given to the plan, to Medi-Cal beneficiaries enrolled in the plan, and others who may be directly interested, including such other persons and organizations as the director may deem necessary. The notice shall state the effective date of, and the reason for, the termination.

(b) In lieu of contract termination specified in subdivision (a), the director shall have the power and authority to take one or more of the following sanctions against a contractor for noncompliance with the findings by the director as specified in subdivision (a):

- (1) Suspend enrollment and marketing activities.
- (2) Require the contractor to suspend or terminate contractor personnel or subcontractors.
- (3) Impose civil penalties not to exceed ten thousand dollars (\$10,000) per violation pursuant to regulations adopted by the



director. Unless imposed in error, penalties shall not be returned to the plan.

(4) Take other appropriate action as determined necessary by the department.

The director shall give reasonable notice of his or her intention to apply any of the sanctions authorized by this subdivision to the plan and others who may be directly interested, including such other persons and organizations as the director may deem necessary. The notice shall include the effective date, the duration of, and the reason for each sanction proposed by the director.

(c) Notwithstanding subdivision (b), the director shall terminate a contract with a prepaid health plan which the United States Secretary of Health and Human Services has determined does not meet the requirements for participation in the Medicaid Program contained in Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(d) Proceedings to impose the sanctions in subdivision (b) shall be governed by the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The director may collect civil penalties by withholding the amount from capitation owed to the plan.

Proceedings to terminate a prepaid health plan contract under subdivisions (a) and (c) shall be governed by the provisions of subdivision (a).

SEC. 9. Section 14408 of the Welfare and Institutions Code is amended to read:

14408. (a) Except as otherwise prohibited by law, a contractor which has entered into a contract with the department pursuant to this chapter may make the benefits known to potential enrollees by methods approved by the department.

(b) No prepaid health plan, marketing representative, or marketing organization shall engage in marketing activities prior to written submittal to and approval by the department. All marketing activities, procedures, methods, and places in which any activities will be conducted shall be explicitly described in a marketing plan and approved by the department prior to being used by a prepaid health plan, marketing representative, or marketing organization. The marketing plan shall be updated and submitted for renewed approval on an annual basis. The department may approve, disapprove, or withdraw approval of any marketing activity or procedure. The department shall require the discontinuance of any marketing activity or procedure for which the department withdraws approval. The conduct of activities or procedures not included in an approved marketing plan shall constitute a violation of this article and be subject to sanctions in accordance with Section 14409.



The prepaid health plan shall be responsible for all presentations by their marketing representatives and for their ethical and professional conduct. The department may withdraw certification for participation in the program from, and impose marketing sanctions specified in Section 14409, as applicable, on, marketing representatives.

(c) The marketing plan shall meet the standards established by the department. The marketing plan shall include, but not be limited to, an explicit description of the specific marketing activities, the method of identifying individual enrollments by marketing representative, and formal measures to monitor performance of marketing representatives and verify both of the following:

(1) The prepaid health plan's marketing activities and practices do not violate subdivision (a) of Section 14409.

(2) Beneficiaries receive complete and accurate information about the benefits and limitations of receiving health care services through the prepaid plan in a manner that considers the beneficiary's level of comprehension.

(d) Each time a marketing representative presents information about the benefits of prepaid health plan enrollment to a beneficiary in order to encourage the beneficiary to enroll, the marketing representative shall leave with the beneficiary printed information identifying the marketing representative by name and prepaid health plan represented.

(e) All printed or illustrated material prepared by the prepaid health plan for dissemination to enrollees or to prospective enrollees shall be submitted to the department prior to such dissemination. The department shall acknowledge receipt of the printed or illustrated material within five days, and shall approve or disapprove the material for dissemination within 60 days after the date of notification that the material has been received. The department may withdraw approval of the material previously approved and order its dissemination discontinued. Where the department notifies the prepaid health plan of its disapproval or withdrawal of approval, the prepaid health plan shall have the right to meet and confer with the director or his or her designee and demonstrate the purpose and reasonable basis for the distribution of such material to enrollees and potential enrollees.

(f) (1) Any form of door-to-door or in-person marketing that coerces or misleads beneficiaries or selectively enrolls beneficiaries on the basis of their health status is unlawful. In addition, on or after July 1, 1996, door-to-door solicitation of Medi-Cal enrollees shall not be permitted.

(2) On or after July 1, 1996, the health care options presentation required by Sections 14016.5 and 14016.6 or the health care options information required by Sections 14087.305 and 14089 shall be fully operational in counties specified by the director for expansion of the



Medi-Cal managed care program or in counties where prepaid health plans are contracting with the department pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96, 14089, and 14089.05. In these counties, on or after July 1, 1996, no enrollment of beneficiaries by prepaid health plans shall occur during in-person marketing activities or during health fairs under paragraph (5) of subdivision (f). Enrollment shall be exclusively performed and transmitted pursuant to the program required by Sections 14016.5, 14016.6 14087.305, and 14089.

(3) In the event the health care options presentation required by Sections 14016.5 and 14016.6 is not fully operational or the health care options information required by Sections 14087.305 and 14089 is not fully available, as specified in paragraph (2) of subdivision (f), the department shall perform the enrollment-only functions until the health care options presentation or information is fully operational or available.

(4) Nothing in this section shall preclude a prepaid health plan from responding to inquiries initiated by beneficiaries or potential beneficiaries.

(5) Until July 1, 1996, a prepaid health plan may participate in an organized community or neighborhood health fair in a public place only if two or more prepaid health plans are participating, or if the plan is invited by the sponsor of the fair. If there are not two or more prepaid health plans providing services to Medi-Cal beneficiaries in a prepaid health plan's service area, this subdivision shall not apply. On or after July 1, 1996, a prepaid health plan may participate in an organized community or neighborhood health fair in a public place for marketing purposes.

(g) Any prepaid health plan, marketing representative, or marketing organization that violates subdivision (f) shall be subject to the sanctions set forth in subdivision (b) of Section 14409 and shall be guilty of a misdemeanor and subject to a fine of five hundred dollars (\$500) or imprisonment in the county jail for six months, or both, for each violation.

(h) The department shall certify each marketing representative prior to participation in the program in accordance with standards established by the department. Continuing certification for participation in the program shall be contingent upon compliance with this article, as well as guidelines and standards adopted by the department, and may be withdrawn upon their violation, as determined by the department. The department may temporarily decertify any marketing representative when that action is necessary to protect the public welfare or the interests of the Medi-Cal program. Temporary decertification shall be effective immediately upon written notice to the marketing representative and the managed care contractor, and shall remain in effect until the department has made a determination on the merits. Temporary



decertification shall be canceled unless the department acts to permanently withdraw certification within 60 days.

(j) No prepaid health plan shall employ in any capacity relating to the marketing operations of the plan a marketing representative whose certification has been withdrawn. Marketing representatives shall not be recertified for participation until the cause for withdrawal of certification has been corrected to the satisfaction of the department. Proof of correction shall be the sole responsibility of the marketing representative.

SEC. 10. Section 14464 is added to the Welfare and Institutions Code, to read:

14464. (a) The department may negotiate and establish an individual administrative cost limit in its contracts with each prepaid health plan or Medi-Cal managed care plan contracting under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) providing services to Medi-Cal beneficiary enrollees.

(b) As used in this section, prepaid health plan or Medi-Cal managed care plan “administrative costs” includes net profit or revenue in excess of expenditures, in addition to those items set forth in Section 1300.78 of Title 10 of the California Code of Regulations and those items set forth by the director.

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

