AMENDED IN SENATE MAY 7, 2008

AMENDED IN ASSEMBLY JANUARY 24, 2008

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CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 158

Introduced by Assembly Member Ma

January 18, 2007

An act to add Article 4.6 (commencing with Section 14146) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 158, as amended, Ma. Medi-Cal: benefits for nondisabled persons infected with chronic hepatitis B.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. Counties are responsible for making eligibility determinations under the Medi-Cal program. One of the methods by which services are provided under the Medi-Cal program is through enrollment of recipients in Medi-Cal managed care plans.

This bill would require the State Department of Health Care Services to expand eligibility for benefits under the existing Medi-Cal program

to include nondisabled persons with chronic hepatitis B infection who would be eligible for Medi-Cal if disabled. This bill would provide that the expansion would be implemented on the date all applicable federal waivers are granted, as specified. The bill would provide that enrollment in Medi-Cal pursuant to the bill would be limited pursuant to an allocation system to be developed by the department. The bill would require the department to meet federal revenue neutrality requirements through the savings generated by voluntary enrollment into Medi-Cal managed care of persons who are disabled as a result of hepatitis B, and who are either receiving Medi-Cal benefits on a fee-for-service basis as of January 1, 2009, or who become eligible to receive Medi-Cal benefits on or after that date. The bill would condition its implementation upon the receipt of federal financial participation and would prohibit the department from enrolling persons in the program established by this bill until the department can ensure sufficient savings equal to or greater than the cost of providing benefits to these persons.

By increasing counties' responsibilities for Medi-Cal eligibility determinations, this bill would impose a state-mandated local program.

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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

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

SECTION 1. Article 4.6 (commencing with Section 14146) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 4.6. Medi-Cal Managed Care Benefits for Nondisabled Persons with Chronic Hepatitis B Infection

14146. (a) It is the intent of the Legislature in enacting this article to expand eligibility for Medi-Cal benefits to persons with

chronic hepatitis B infection who are not disabled, but who, if disabled, would qualify for Medi-Cal benefits.

(b) It is further the intent of the Legislature that this expansion of the existing Medi-Cal program be funded by cost savings achieved through the voluntary enrollment into the existing Medi-Cal managed care program of persons who are disabled as a result of hepatitis B, and who are either receiving Medi-Cal benefits on a fee-for-service basis as of January 1, 2009, or who become eligible to receive Medi-Cal benefits on or after January 1, 2009.

(c) It is further the intent of the Legislature that the department encourage the voluntary enrollment into the existing Medi-Cal managed care program of persons described in subdivision (b) in order to obtain sufficient cost savings to provide Medi-Cal benefits to the maximum feasible number of persons with chronic hepatitis B infection subject to the constraints of this article.

(d) It is further the intent of the Legislature that all protections of state and federal law and regulations that apply to the state's Medi-Cal managed care program shall apply to those persons who become eligible for Medi-Cal pursuant to this article.

14146.1. (a) Subject to subdivisions (b) and (c), paragraph (2) of subdivision (f), and subdivision (k), the department shall, commencing July 1, 2009, or the date that all necessary federal waivers have been obtained, whichever is later, expand eligibility for benefits under this chapter to any person with chronic hepatitis B infection who would otherwise qualify for Medi-Cal benefits if the person were disabled as defined in subdivision (h).

(b) Any person eligible for benefits pursuant to subdivision (a), and seeking enrollment in Medi-Cal pursuant to this article, shall be enrolled on a first-come-first-served basis pursuant to an allocation mechanism that shall be developed by the department. *The department shall use the allocation mechanism to ensure that the revenue neutrality requirements provided for in subdivision (f) are met.*

(c) Any person who is eligible for enrollment in Medi-Cal pursuant to this article shall be required to elect a Medi-Cal managed care plan in those counties in which a managed care plan is available, unless the department determines that the ~~cost-neutrality~~ *revenue neutrality* requirements provided for in

subdivision (f) and the enrollment goals provided for in this article can be achieved without this requirement.

(d) In implementing this article, the department shall ensure that all of the following standards are met:

(1) All state and federal laws and regulations that apply to the state's Medi-Cal managed care program shall apply to the expansion provided by this article and to the beneficiaries eligible for Medi-Cal pursuant to this article.

(2) All participating plans that assume full risk for all health care services, including inpatient and outpatient services, shall be 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), except as provided in Section 1343 of the Health and Safety Code.

(3) Health care service plans participating in the Medi-Cal managed care program shall comply with the applicable sections of 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), including*, but not limited to,* Sections 1367 and 1374.16 of the Health and Safety Code and the regulations adopted pursuant to Section 1374.16 of the Health and Safety Code.

(4) Primary care case management plans participating in the Medi-Cal managed care program shall comply with the applicable sections of Article 2.9 (commencing with Section 14088). Primary care case management plans are required to maintain grievance and appeal procedures consistent with the existing Medi-Cal managed care program, to address beneficiary grievances.

(e) The department shall establish capitation rates to be paid to Medi-Cal managed care plans for services provided pursuant to ~~this section. These capitation rates shall not exceed 95 percent of the fee-for-service equivalent costs to the Medi-Cal program for medical services for persons with chronic hepatitis B infection.~~ *this section. The department shall report to the appropriate policy and fiscal committees of the Legislature on the specific methodology used to develop the capitation rates described in this subdivision. The methodology used by the department shall ensure that the rates are actuarially sound, based on data specific to people with chronic hepatitis B infection, and in compliance with subsection (c) of Section 438.6 of Title 42 of the Code of Federal Regulations.*

(f) (1) The department shall meet federal revenue neutrality requirements through the savings generated by the voluntary enrollment into Medi-Cal managed care of persons who are disabled as a result of hepatitis B, and who are either receiving Medi-Cal benefits on a fee-for-service basis as of January 1, 2009, or who become eligible to receive Medi-Cal benefits on or after January 1, 2009. The savings generated by increased voluntary enrollments in Medi-Cal managed care shall be used to fund enrollment by individuals eligible for the expansion of Medi-Cal eligibility provided for pursuant to subdivision (a). Nothing in this subdivision shall preclude the department from implementing other means of meeting the federal revenue neutrality requirements, provided that all requirements of this article are met.

(2) The department shall not enroll individuals described in subdivision (a) until the department can ensure sufficient savings, pursuant to paragraph (1), equal to or greater than the cost of providing benefits to these individuals.

(g) The department shall encourage the voluntary enrollment into Medi-Cal managed care of persons who are disabled as a result of hepatitis B. The department shall conduct all outreach and awareness activities necessary to implement this requirement in a manner consistent with Section 14407 to ensure that persons who enroll in managed care do so voluntarily. These outreach and awareness activities shall include information on how electing managed care may alter provider relationships and how persons may revert to fee-for-service if they prefer to return to fee-for-service.

(h) For the purposes of this section, “disabled” means a person who meets the eligibility criteria 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).

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this article, without taking any regulatory action, by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(j) Commencing January 1, 2009, the department shall seek the appropriate federal waiver under Section 1115 of the Social Security Act (42 U.S.C. Sec. 1315) to implement the expansion of eligibility provided for pursuant to this section. The department shall maximize the federal reimbursement received for services provided under this article to those eligible pursuant to this section.

(k) This article shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(*l*) The department may seek federal reimbursement for its initial costs in developing and implementing the expansion of eligibility provided for pursuant to this section. For purposes of this subdivision, "initial costs" means those costs incurred before the receipt of any federal waivers granted under Section 1115 of the Social Security Act (42 U.S.C. Sec. 1315).

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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