AMENDED IN SENATE APRIL 16, 2009

SENATE BILL No. 311

Introduced by Senator Alquist

February 25, 2009

~~An act to amend Section 14459.5 of the Welfare and Institutions Code, relating to Medi-Cal.~~ *An act to add Section 12693.265 to the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

SB 311, as amended, Alquist. ~~Medi-Cal: managed care.~~ *Healthy Families Program: dental-only coverage.*

Existing law, the federal Children's Health Insurance Program Reauthorization Act of 2009, authorizes states with a separate Children's Health Insurance Program to provide dental-only supplemental coverage to children who are enrolled in group health care coverage or health insurance coverage offered through an employer and who would otherwise satisfy the requirements for being a targeted low-income child, as specified.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, dental, and vision benefits to eligible children pursuant to the federal Children's Health Insurance Program.

This bill would, contingent on the receipt and appropriation of funds, require the board to provide dental-only coverage consistent with the federal Children's Health Insurance Program Reauthorization Act of 2009, as specified, and would authorize the board to adopt regulations to implement that requirement.

The bill would also state the intent of the Legislature to enact legislation that would implement other provisions of the federal Children's Health Insurance Program Reauthorization Act of 2009.

~~Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which health care services are provided to qualified low-income persons.~~

~~Existing law, the Waxman-Duffy Prepaid Health Plan Act, allows the department to contract with prepaid health plans to provide the benefits authorized under Medi-Cal, providing Medi-Cal beneficiaries the opportunity to enroll as regular subscribers in prepaid health plans, as specified.~~

~~Under existing law, the department has responsibility for monitoring the quality of all Medicaid services provided in the state.~~

~~This bill would require the department to establish minimum quality standards, in accordance with a prescribed timeframe, for the provision of primary, preventive, and acute health care services, as prescribed. It would permit the department to impose penalties for violation of the standards, and would require that any savings derived from these penalties be allocated to plans demonstrating superior performance, as specified.~~

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. The Legislature hereby finds and declares all of the following:

(a) Congress and the President have reauthorized the federal Children's Health Insurance Program, which provides funding for the state's Healthy Families Program.

(b) The reauthorization legislation has provided additional funding for children's health insurance and additional flexibility to states to improve and expand health care coverage for children.

(c) Although more than nine of every 10 children in California have health care coverage, about 683,000 children in the state are without health care coverage according to 2007 data from the Center for Health Policy Research at the University of California at Los Angeles.

(d) It is imperative that the state act to take advantage of the increased federal funding and enhanced flexibility in administering the federal Children's Health Insurance Program.

(e) It is the intent of the Legislature to enact legislation that would implement the key elements of the federal Children's Health Insurance Program Reauthorization Act of 2009, including receiving federal matching funds for enrolling eligible immigrant children, implementing changes to citizen documentation requirements, ensuring parity in state coverage, establishing new payment methods for clinics participating in the Healthy Families Program, measuring quality of care within public programs, and taking advantage of the increased federal funding that is available to California, including bonuses and targeted grant programs, such as performance bonuses and outreach funding.

SEC. 2. Section 12693.265 is added to the Insurance Code, to read:

12693.265. (a) Subject to subdivisions (b) and (c), the board shall provide dental-only coverage as authorized by Section 501 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3). To be eligible to receive this coverage, a child shall be an eligible child, as described in subdivision (a) of Section 12693.70, except that the child shall be enrolled in employer-sponsored coverage that does not provide dental benefits or cost sharing that meets the requirements of Section 12693.63 and its implementing regulations.

(b) The board may adopt, and may only one time readopt, regulations to implement subdivision (a). The adoption and one-time readoption of a regulation authorized by this subdivision is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(c) This section shall be implemented only if and to the extent that federal financial participation is obtained and only if and to the extent that funds are appropriated by the Legislature for purposes of this section in the annual Budget Act or in another statute.

~~SECTION 1. Section 14459.5 of the Welfare and Institutions Code is amended to read:~~

~~14459.5. (a) As delegated by the federal government, the department has responsibility for monitoring the quality of all Medicaid services provided in the state. A key component of this monitoring function is the performance of annual, independent, external reviews of the quality of services furnished under each state contract with a health maintenance organization, as specified by the federal Health Care Financing Administration.~~

~~(b) (1) The department shall establish minimum quality standards for the provision of primary, preventive, and acute health care services provided by the health maintenance organizations under contract with the department. These standards shall be based on the Healthcare Effectiveness Data and Information Set (HEDIS) measures for the External Accountability Set that each plan is required to report annually to the department. The External Accountability Set shall include a sufficient number of measures to adequately monitor the managed care plans' provision of services to its full range of enrollees, including, but not limited to, children, women, individuals with a disability, and adults with chronic conditions. The department shall require the External Quality Review Organization that produces the annual Performance Measures For Medi-Cal Managed Care Members report to prepare the report in full compliance with the conventions of the National Committee for Quality Assurance.~~

~~(2) In implementing this subdivision, it is the intent of the Legislature that the department establish policies that will result in all Medi-Cal managed care plans performing at no less than the 50th percentile level of HEDIS by January 1, 2015, based on the most recent national Medicaid rates for any measure reported to the department.~~

~~(3) The minimum standards established by the department shall include, but not be limited to, the following:~~

~~(A) Prior to July 1, 2012, managed care plans shall be required to perform at no less than the 25th percentile of HEDIS, based on the most recent national Medicaid rates for all measures reported to the department.~~

~~(i) Commencing no later than April 1, 2010, the department shall annually identify plans that perform below the 25th percentile of HEDIS, based on the most recent national Medicaid rates for any measure reported to the department. The department shall require these managed care plans to develop a corrective action~~

~~plan that identifies specific interventions that will improve performance.~~

~~(ii) Commencing January 1, 2012, a Medi-Cal managed care plan that has submitted a corrective action plan and continues to perform below the 25th percentile of HEDIS, based on the most recent national Medicaid rates for any measure reported to the department, shall not be eligible for the assignment of new Medi-Cal enrollees who have not selected a managed care plan and would otherwise be enrolled in that plan by the department through the default algorithm. Additionally, the 10 percent cap that limits the number of defaulted beneficiaries that a plan can lose from the prior year shall be lifted for the managed care plans performing below the 25th percentile of HEDIS.~~

~~(iii) Commencing July 1, 2014, the department may impose a financial penalty by withholding up to 5 percent of a Medi-Cal managed care plan's contract rate, if that plan continues to perform below the 25th percentile of HEDIS for any measure reported to the department.~~

~~(B) Prior to July 1, 2015, managed care plans shall be required to perform at no less than the 50th percentile of HEDIS, based on the most recent national Medicaid rates for all measures reported to the department.~~

~~(i) Commencing no later than April 1, 2013, the department shall annually identify managed care plans that perform below the 50th percentile of HEDIS, based on the most recent national Medicaid rates for any measure reported to the department. The department shall require these managed care plans to develop a corrective action plan that identifies specific interventions that will improve performance.~~

~~(ii) Commencing January 1, 2015, a Medi-Cal managed care plan that has submitted a corrective action plan and continues to perform below the 50th percentile of HEDIS, based on the most recent national Medicaid rates for any measure reported to the department, shall not be eligible for the assignment of new Medi-Cal enrollees who have not selected a managed care plan and would otherwise be enrolled in that plan by the department through the default algorithm. Additionally, the 10 percent cap that limits the number of defaulted beneficiaries that a plan can lose from the prior year shall be lifted for the managed care plans performing below the 50th percentile of HEDIS.~~

~~(iii) Commencing July 1, 2017, the department may impose a financial penalty by withholding up to 5 percent of a Medi-Cal managed care plan's contract rate, if that plan continues to perform below the 50th percentile of HEDIS for any measure reported to the department.~~

~~(4) The department shall allocate any savings derived from penalties imposed pursuant to paragraph (3) to plans that have demonstrated superior performance, as indicated by either performance above the 75th percentile of, or substantial improvement in, HEDIS, based on the most recent national Medicaid rates for any measure reported to the department.~~

~~(c) The Legislature finds and declares that the final report obtained from the external reviews will provide valid and reliable information regarding health care outcomes and the overall quality of care delivered by the managed care plans.~~

~~(d) The department shall make only the final report of each external review available, within 30 calendar days of completion, to the fiscal and health policy committees of the Legislature, and shall make only the final report available for public viewing upon request by any individual or organization.~~

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