ASSEMBLY BILL No. 2472

Introduced by Assembly Members Butler and Bonnie Lowenthal
(Principal coauthor: Senator Price)

February 24, 2012

An act to amend Section 14301.1 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 2472, as introduced, Butler. Medi-Cal: managed care.

Existing law requires the State Department of Health Care Services to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and authorizes the department to establish health-plan- and county-specific rates. Existing law requires the department to utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to specified provisions that govern certain managed health care models.

This bill would require the department to utilize fee-for-service data in setting rates for an entity that has contracted with the department as a primary care case management organization pursuant to specified provisions of law, including provisions that authorize the department to contract with primary care providers that serve persons infected with human immunodeficiency virus (HIV), in the same manner and for the same purposes as it used this data to establish rates for other specified managed care health care models.

The bill would make various findings and declarations relating to the AIDS Healthcare Foundation.

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 finds and declares all of the following:

(a) The AIDS Healthcare Foundation (AHF) has been providing services to people with HIV and AIDS since 1987 and opened its first health care clinic in 1991.

(b) AHF now has 12 health care clinics in California with 10 of them in the Los Angeles metropolitan area. All of the clinics provide coordinated, highly specialized care to Medi-Cal beneficiaries.

(c) For many years, AHF has been classified as a primary care case management organization under the Medi-Cal program and obtained a Knox-Keene license in 2005 to accept capitated payments for all services except inpatient care. Because AHF has been a uniquely structured Medi-Cal managed care entity, the State Department of Health Care Services annually has formulated a provider rate specific to AHF. This rate has been set using a fee-for-service methodology that is no longer used when calculating rates for Medi-Cal managed care plans.

(d) AHF has been a long-time advocate for managed care for persons with disabilities, including chronic medical conditions like HIV and AIDS. Given the state's continued expansion and enrollment of special populations into managed care, AHF has amended its Knox-Keene license and will be able to continue serving patients with HIV and AIDS for a comprehensive set of benefits, including inpatient hospitalization.

(e) Through three unique managed care models, the Medi-Cal Program contracts with several types of managed care organizations throughout California. These plans include county organized health systems, local initiatives, nonprofit health plans and commercial health plans. All of these plans are licensed and regulated under the Knox-Keene Act as well as having additional oversight and contract requirements through the department. AHF is one of these licensed managed care organizations contracting with the department.

(f) Section 1903(m)(2)(A)(iii) of the federal Social Security Act requires states, including California, to pay Medicaid health plan rates that are actuarially sound. The Centers for Medicare and Medicaid Services (CMS) has defined actuarial sound capitation rates through regulation (42 C.F.R. 438.6) as rates that are (1) developed in accordance with generally accepted actuarial principles and practices; (2) appropriate for the populations to be covered and the services to be furnished; and (3) certified as meeting applicable regulatory requirements by qualified actuaries.

(g) The department currently develops actuarially-based rates for its Medi-Cal managed care plans by contract. These rates are annually reviewed by the Legislature through the budget process to ensure they assure appropriate payment for health care services to Medi-Cal beneficiaries while also protecting state funds.

(h) Given AHF's continued dedication to providing specialized managed care services to Medi-Cal beneficiaries living with HIV and AIDS and its recently-expanded capacity to include inpatient services as part of its contract with the department, it is seeking to ensure that its capitated rate is developed in the same manner as all other Medi-Cal managed care plans.

(i) It is the intent of the Legislature in enacting this legislation that the department develop a new capitated rate for AHF in the same manner as it currently develops rates for its other contracting managed care plans.

SEC. 2. Section 14301.1 of the Welfare and Institutions Code is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by

the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(i) This section shall apply to an entity that has contracted with the department as a primary care case management organization pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 and subsequently is licensed as a health care plan pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. The department shall utilize fee-for-service data in setting rates pursuant to this subdivision in the same manner and for all the same purposes as it used this data to establish rates for all categories of aid groupings for all health plans operating pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7.

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(j) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

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(k) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

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