AB-2724 Medi-Cal: alternate health care service plan. (2021-2022)

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Assembly Bill No. 2724

CHAPTER 73

An act to amend Sections 14094.4, 14094.5, and 14094.6 of, and to add Section 14197.11 to, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor June 30, 2022. Filed with Secretary of State June 30, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2724, Arambula. Medi-Cal: alternate health care service plan.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for certain eligible beneficiaries in geographic regions designated by the department, as specified. The bill would authorize the department to contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available, for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market. The bill would, among other things, prohibit the AHCSP from denying enrollment to any of those eligible beneficiaries, unless the department or the Department of Managed Health Care has ordered the AHCSP to cease enrollment in an applicable service area. The bill would require the contract with the AHCSP to include the same standards and requirements, except with respect to enrollment, as for other Medi-Cal managed care plans, as specified. The bill would require the Health Care Options Program, which is an entity overseen by the department for Medi-Cal managed care education and enrollment, to disenroll any member of an AHCSP if the member meets any one of the reasons for disenrollment enumerated in certain regulations, except as specified.

The bill would require the AHCSP to enter into a memorandum of understanding (MOU) with the department, which would include specified standards or requirements and the AHCSP's commitment to increase enrollment of new Medi-Cal members and any requirements related to the AHCSP's collaboration with and support of applicable safety net providers. The bill would require the department to post the MOU and a specified implementation report on its internet website.

The bill would require the AHCSP, as part of the MOU, to work with federally qualified health centers (FQHCs) in AHCSP service areas selected by the AHCSP and the department, at the request of the FQHC, to provide assistance with population health management and clinical transformation. The bill would require the department and the AHCSP to identify the highest need specialties and geographic areas where the AHCSP would provide outpatient specialty care and services to address related needs, as specified.

The bill would require the AHCSP to periodically consult with counties and other affected local stakeholders in those geographic regions in which the AHCSP operates, as specified. The bill would require the AHCSP to enter into MOUs with local agencies pursuant to Medi-Cal managed care contract requirements.

Under the bill, except when an AHCSP was already contracted with the department as a Medi-Cal managed care plan as of January 1, 2022, contracts entered into pursuant to these provisions would be effective no sooner than January 1, 2024, as specified. The bill would require that the capitation rates established for contracts be set annually in accordance with related provisions, as specified.

The bill would require the department to conduct an assessment of the AHCSP's readiness to meet behavioral health network adequacy requirements, and to post those findings on the department's internet website, as specified.

The bill would authorize the department to implement these provisions through plan letters or other similar instructions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would require the department to report to the health and fiscal committees of the Legislature, in 2026, to provide an update on the implementation of these provisions.

Existing law authorizes the department to establish a Whole Child Model program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties provide California Children's Services (CCS) to Medi-Cal eligible CCS children and youth.

This bill would, commencing no sooner than January 1, 2024, expand managed care plans under the Whole Child Model program to also include the above-described AHCSPs.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14094.4 of the Welfare and Institutions Code is amended to read:

14094.4. For the purposes of this article, the following definitions shall apply:

(a) "CCS provider" means any of the following:

(1) A medical provider that is paneled by the CCS program to treat a CCS-eligible condition pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

(2) A licensed acute care hospital approved by the CCS program to treat a CCS-eligible condition.

(3) A special care center approved by the CCS program to treat a CCS-eligible condition.

(b) "County organized health system" or "COHS" means:

(1) A county organized health system contracting with the department to provide Medi-Cal services to beneficiaries pursuant to Article 2.8 (commencing with Section 14087.5).

(2) A regional health authority.

(c) "Medi-Cal managed care plan" means a COHS, or, commencing no sooner than January 1, 2024, an alternate health care service plan contracted with the department pursuant to Section 14197.11 in any county described in Section 14094.5.

SEC. 2. Section 14094.5 of the Welfare and Institutions Code is amended to read:

14094.5. No sooner than July 1, 2017, the department may establish a Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in a managed care plan served by a county organized health system or Regional Health Authority, or commencing no sooner than January 1, 2024, an alternate health care service plan contracted with the department pursuant to Section 14197.11, in the following counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

SEC. 3. Section 14094.6 of the Welfare and Institutions Code is amended to read:

14094.6. The goals for the Whole Child Model program for children and youth under 21 years of age who meet the eligibility requirements of Section 123805 of the Health and Safety Code and are enrolled in a managed care plan under a county

organized health system or Regional Health Authority, or an alternate health care service plan contracted with the department pursuant to Section 14197.11, shall include all of the following:

(a) Improving the coordination of primary and preventive services with specialty care services, medical therapy units, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), long-term services and supports (LTSS), regional center services, and home- and community-based services using a child and youth and family-centered approach.

(b) Maintaining or exceeding CCS program standards and specialty care access, including access to appropriate subspecialties.

(c) Providing for the continuity of child and youth access to expert, CCS dedicated case management and care coordination, provider referrals, and service authorizations.

(d) Improving the transition of youth from CCS to adult Medi-Cal managed systems of care through better coordination of medical and nonmedical services and supports and improved access to appropriate adult providers for youth who age out of CCS.

(e) Identifying, tracking, and evaluating the transition of children and youth from CCS to the Whole Child Model program to inform future CCS program improvements.

SEC. 4. Section 14197.11 is added to the Welfare and Institutions Code, to read:

14197.11. (a) Notwithstanding any other law, subject to subdivisions (e) and (g), the department may enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP) to serve as a primary Medi-Cal managed care plan for eligible beneficiaries described in subdivision (b) in geographic regions that are designated by the department pursuant to subdivision (c) and that are regions in which the AHCSP already provides commercial coverage in the individual, small group, or large group market.

(b) The following beneficiary populations enrolling in Medi-Cal managed care shall be eligible to enroll, or choose to maintain their enrollment, in an AHCSP contracted with the department pursuant to subdivision (a):

(1) A beneficiary who was previously a member of the AHCSP as their Medi-Cal managed care plan at any point from January 1, 2023, to December 31, 2023, inclusive.

(2) An existing member of the AHCSP who is transitioning into Medi-Cal managed care.

(3) A beneficiary who was a member of the AHCSP at any time during the 12 months preceding the effective date of the beneficiary's Medi-Cal eligibility.

(4) A beneficiary with an AHCSP family linkage.

(5) A beneficiary who was previously enrolled in a primary Medi-Cal managed care plan other than the AHCSP at any point from January 1, 2023, to December 31, 2023, inclusive, but who was assigned to, and made the responsibility of, the AHCSP under a subcontract with the Medi-Cal managed care plan.

(6) A dual eligible beneficiary residing in a geographic region approved by the department for purposes of this subdivision and for which the department has contracted with the AHCSP pursuant to subdivision (a).

(7) A beneficiary who is in foster care in this state or is otherwise eligible on the basis of their receipt of services through a child welfare agency pursuant to Section 300 or a former foster youth eligible pursuant to Section 14005.28 residing in a geographic region for which the department has contracted with the AHCSP pursuant to subdivision (a). A beneficiary who was previously enrolled in the AHCSP as their primary Medi-Cal managed care plan under this paragraph may remain in the AHCSP even if the beneficiary is no longer receiving services through a child welfare agency pursuant to Section 300.

(8) (A) A beneficiary not listed in paragraphs (1) to (7), inclusive, who resides in a geographic region for which the department has contracted with the AHCSP pursuant to subdivision (a) and is assigned to the AHCSP according to the department's default enrollment process for beneficiaries that fail to elect a Medi-Cal managed care plan in accordance with Section 14016.5. The department shall annually determine the rate of default enrollment for beneficiaries into the AHCSP in each applicable county or geographic region based on the AHCSP's projected capacity.

(B) If the default enrollment into the AHCSP described in subparagraph (A) results in a default rate of 20 percent or higher for two consecutive months in an applicable county or counties as described in subdivision (c) of Section 14016.55, the department may elect not to conduct a one-time beneficiary survey, notwithstanding the requirement of subdivision (c) of Section 14016.55.

(c) Notwithstanding any other law, the department may contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available and received pursuant to subdivision (g), for which the

AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market. To the extent permissible under federal law, the department may enter into either a single comprehensive risk contract for all geographic areas where the AHCSP is approved to operate as a Medi-Cal managed care plan or multiple contracts to serve the different geographic areas. If the department enters into a single comprehensive risk contract, capitation rates shall be determined on a county or regional basis.

(1) The AHCSP shall not deny enrollment to any individual eligible pursuant to subdivision (b) unless the department or the Department of Managed Health Care has ordered the AHCSP to cease enrollment in an applicable service area.

(2) (A) The AHCSP shall not, on its own, disenroll any eligible beneficiary described in subdivision (b).

(B) The Health Care Options Program shall disenroll any member of an AHCSP if the member meets any one of the reasons for disenrollment enumerated in Section 53891 of Title 22 of the California Code of Regulations, except that the Health Care Options Program shall not disenroll a member who meets the conditions described in subdivision (f) of Section 53845 of Title 22 of the California Code of Regulations. The Health Care Options Program shall follow the disenrollment process described in Section 53889 of Title 22 of the California Code of Regulations.

(3) Except for those standards and requirements relating to beneficiary enrollment that the department determines are inapplicable to the AHCSP, the comprehensive risk contract or contracts with the AHCSP pursuant to this section shall include the same standards and requirements as those for other Medi-Cal managed care plans, including any requirements imposed by the CalAIM Terms and Conditions, as the term is defined in subdivision (c) of Section 14184.101, and any terms and conditions imposed by a successor federal waiver or demonstration project and the same standards and requirements as for other Medi-Cal managed care plans in effect at that time.

(4) (A) In addition to the comprehensive risk contract or contracts described in this section, the AHCSP shall enter into a memorandum of understanding with the department to memorialize any standards or requirements that are in addition to, or different than, those imposed on other Medi-Cal managed care plans as described in paragraph (3). Upon execution, the department shall post the memorandum of understanding on its internet website.

(B) The memorandum of understanding entered into pursuant to subparagraph (A) shall include, but need not be limited to, the AHCSP's commitment to increase enrollment of new Medi-Cal members over the course of the relevant contract terms and any requirements related to the AHCSP's collaboration with, and support of, applicable safety net providers, including federally qualified health centers (FQHCs), as follows:

(i) The AHCSP shall work with FQHCs in AHCSP service areas selected by the AHCSP and the department, at the request of the FQHC, to provide assistance with population health management and clinical transformation.

(ii) The department and the AHCSP shall identify the highest need specialties and geographic areas where the AHCSP will provide, using the AHCSP's physicians, outpatient specialty care and services to address related needs, including, but not limited to, diagnostic testing and outpatient procedures for Medi-Cal beneficiaries who are not enrollees of the AHCSP.

(C) Within six months after the end of each applicable rating period for which the department contracts with the AHCSP pursuant to this section, commencing with the 2024 calendar year, the department shall publish a report describing the implementation of those standards and requirements imposed by the memorandum of understanding for the applicable rating period and post the report on its internet website.

(5) During the relevant terms of the contracts entered into pursuant to subdivision (a), the AHCSP shall periodically consult with counties and other affected local stakeholders in those geographic regions in which the AHCSP operates, in a form and manner as directed by the department. The AHCSP shall enter into memoranda of understanding with local agencies pursuant to Medi-Cal managed care contract requirements.

(d) It is the intent of the Legislature that Medi-Cal beneficiaries enrolled in the AHCSP be assigned to a primary care physician who is contracted with the AHCSP through its exclusive contracts with a single medical group subject to the limitations imposed by federal law.

(e) Except when an AHCSP was already contracted with the department as a Medi-Cal managed care plan as of January 1, 2022, contracts entered into pursuant to subdivision (a) shall be effective no sooner than January 1, 2024.

(f) Before the initial effective date of a contract entered into pursuant to this section, the department shall conduct an assessment of the AHCSP's readiness to meet behavioral health network adequacy requirements pursuant to Medi-Cal managed care

contract requirements and Section 14197 and shall post those findings on the department's internet website, including any corrective action plan imposed due to noncompliance and the department's basis for that finding of noncompliance, if any.

(g) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(h) The capitation rates established for contracts entered into pursuant to subdivision (a) shall be set annually in accordance with Section 14301.1. It is the intent of the Legislature that all Medi-Cal managed care plans be paid in an actuarially sound manner according to the projected acuity of the populations they serve under contract with the department.

(i) 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, in whole or in part, by means of plan letters or other similar instructions, without taking any further regulatory action.

(j) Notwithstanding any other law, contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(k) For purposes of this section, the following definitions shall apply:

(1) "Alternate health care service plan" means a nonprofit health care service plan with at least 4,000,000 enrollees statewide that owns or operates pharmacies and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it 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). If the AHCSP cannot comply with any terms of the Knox-Keene Health Care Service Plan Act, it shall request a modification of its license from the Department of Managed Health Care pursuant to Section 1352 of the Health and Safety Code, including regulations promulgated thereunder, or request an exemption from the Department of Managed Health Care pursuant to subdivision (b) of Section 1343 of the Health and Safety Code.

(2) "AHCSP family linkage" includes when any of the following individuals are current AHCSP members on the effective date of the beneficiary's Medi-Cal eligibility.

(A) A beneficiary's spouse or domestic partner.

(B) A beneficiary's dependent child, foster child, or stepchild under 26 years of age.

(C) A beneficiary's dependent who is disabled and over 21 years of age.

(D) A parent or stepparent of a beneficiary under 26 years of age.

(E) A beneficiary's grandparent, guardian, foster parent, or other relative of a beneficiary under 26 years of age with appropriate documentation of familial relationship, as determined by the department.

(3) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(4) "Dual eligible beneficiary" has the same meaning as set forth in paragraph (1) of subdivision (f) of Section 14184.200.

(5) "Medi-Cal managed care plan" has the same meaning as set forth in subdivision (j) of Section 14184.101.

(6) "Member" means an enrollee of the AHCSP. A beneficiary is not an enrollee solely by virtue of receiving a service through an AHCSP provider or AHCSP-contracted provider.

(l) In 2026, the department shall report to the health and fiscal committees of the Legislature to provide an update on the implementation of this section.