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AB-614 Medi-Cal. (2023-2024)

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Assembly Bill No. 614

CHAPTER 266

An act to amend Sections 14017.7, 14093.05, 14308, 14450, 14452, 14457, 14459, 15850, 15850.1, and 15850.5 of, and to amend the heading of Chapter 3 (commencing with Section 15850) of Part 3.3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 30, 2023. Filed with Secretary of State September 30, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

AB 614, Wood. Medi-Cal.

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. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans.

Existing law establishes, under Medi-Cal, the County Health Initiative Matching Fund, a program administered by the department, through which an applicant county, county agency, local initiative, or county organized health system that provides an intergovernmental transfer, as specified, is authorized to submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to certain children. The program is sometimes known as the County Children's Health Initiative Program (CCHIP).

This bill would revise certain provisions to rename that program as CCHIP.

Existing law requires the Director of Health Care Services to enter into contracts with managed care plans under Medi-Cal and related provisions, including health maintenance organizations, prepaid health plans, or other specified entities, for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs.

This bill would delete that list of entities and would instead specify that the director would be required to enter into contracts with managed care plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, except as otherwise authorized under the Medi-Cal program. The bill would require the director, prior to issuing a new request for proposal or entering into new contracts, to provide an opportunity for interested stakeholders to provide input to inform the development of contract provisions.

The bill would also make technical changes to some of the provisions described above.

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

SECTION 1. Section 14017.7 of the Welfare and Institutions Code is amended to read:

14017.7. (a) In addition to the issuance of Medi-Cal cards, pursuant to Section 14017.8, the department may issue a benefits identification card for the purpose of identifying an individual who has been determined eligible for health care benefits under this chapter or health care benefits under another health care program administered by the department, including, but not limited to, the Medi-Cal Access Program as described in Chapter 2 (commencing with Section 15810) of Part 3.3, or both.

(b) The department may also issue a benefits identification card for the purpose of identifying an individual who has been determined eligible to receive health care services from a Medi-Cal provider under the Healthy Families Program under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, if children are enrolled back into that program pursuant to subdivision (m) of Section 14005.26 or subdivision (q) of Section 14005.27.

(c) In no event shall a benefits identification card be issued to an individual described in subdivision (a) or (b) unless appropriate and adequate safeguards have been implemented to ensure all of the following:

(1) If the individual has been determined eligible for health care benefits under another health care program administered by the department or a program identified in subdivision (b), that health care program pays for any and all health care benefits delivered to the individual by that health care program.

(2) State funds appropriated to or federal Medicaid financial participation claimed by the Medi-Cal program shall only be used for the delivery of health care benefits authorized pursuant to this chapter.

(d) The individual described in subdivision (a) or (b) may present the benefits identification card to obtain health care benefits for which that individual has been determined eligible under this chapter, or health care benefits under another health care program administered by the department or a program identified in subdivision (b), or all of them.

(e) Where applicable, all laws, regulations, restrictions, conditions, and terms of participation regarding the possession, billing, and use of Medi-Cal cards shall also apply to a benefits identification card.

(f) For the purposes of this section, "benefits" includes medically necessary services, goods, supplies, or merchandise.

SEC. 2. Section 14093.05 of the Welfare and Institutions Code is amended to read:

14093.05. (a) (1) Except as otherwise authorized pursuant to this chapter, the director shall enter into contracts, under this chapter and Chapter 8 (commencing with Section 14200), with managed care plans 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), for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. The director may also amend existing Medi-Cal managed care contracts to include the provision of medical benefits to persons who are eligible to receive medical benefits under publicly supported programs. Contracts may be on an exclusive or nonexclusive basis.

(2) Prior to issuing a new request for proposal or entering into new contracts pursuant to paragraph (1), the director shall provide an opportunity for interested stakeholders to provide input to inform the development of contract provisions.

(b) Contractors pursuant to this article and participating providers acting pursuant to subcontracts with those contractors, shall agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the contractor does not ensure sufficient funding to cover program benefits.

(c) Any managed care contractor serving children with conditions eligible under the California Children's Services (CCS) program shall maintain and follow standards of care established by the program, including use of paneled providers and CCS-approved special care centers and shall follow treatment plans approved by the program, including specified services and providers of services. If there are insufficient paneled providers willing to enter into contracts with the managed care contractor, the program shall seek to establish new paneled providers willing to contract. If a paneled provider cannot be found, the managed care contractor shall seek program approval to use a specific nonpaneled provider with appropriate qualifications.

(d) (1) Any managed care contractor serving children with conditions eligible under the CCS program shall report expenditures and savings separately for CCS-covered services and CCS-eligible children.

(2) If the managed care contractor is paid according to a capitated or risk-based payment methodology, there shall be separate actuarially sound rates for CCS-eligible children.

(3) Notwithstanding paragraph (2), a managed care pilot project may, if approval is obtained from the State CCS program director, utilize an alternative rate structure for CCS-eligible children.

(e) This article is not intended to and shall not be interpreted to permit any reduction in benefits or eligibility levels under the CCS program. Any medically necessary service not available under the managed care contracts authorized under this article shall remain the responsibility of the state and county.

(f) To assure CCS benefits are provided to enrollees with a CCS-eligible condition according to CCS program standards, there shall be oversight by the state and local CCS program agencies for both services covered and not covered by the managed care contract.

(g) Any managed care contract that will affect the delivery of care to CCS-eligible children shall be approved by the state CCS program director prior to execution. The state CCS program shall continue to be responsible for selection of CCS-paneled providers and monitoring of contractors to see that CCS state standards are maintained.

SEC. 3. Section 14308 of the Welfare and Institutions Code is amended to read:

14308. (a) Each prepaid health plan shall furnish to the director such information and reports as required by Title XIX of the federal Social Security Act.

(b) The director may require a prepaid health plan to provide the director with information and reports that are furnished by the prepaid health plan to the Director of the Department of Managed Health Care pursuant to the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the Knox-Keene Health Care Service Plan Act of 1975.

(c) The director may, by regulation, require plans to furnish statistical information to the extent the information is necessary for the department to establish rates of payment pursuant to Section 14301.1 and to provide reports pursuant to Section 14313. The department shall, to the extent feasible, accept this information in a form which is consistent with reports required to be provided pursuant to the Knox-Keene Health Care Service Plan Act of 1975. In the case of a hospital based plan that is a health maintenance organization qualified pursuant to Title XIII of the federal Public Health Service Act, and that has more than one million enrollees, of whom less than 10 percent are Medi-Cal enrollees, information required pursuant to this subdivision shall consist of reports required to be made to the United States Department of Health and Human Services pursuant to Title XIII of the federal Public Health Service Act.

SEC. 4. Section 14450 of the Welfare and Institutions Code is amended to read:

14450. (a) No contract between the department and a prepaid health plan shall be approved or renewed unless the providers and the facilities of the prepaid health plan meet the Medi-Cal program standards for participation as established by the director. In addition, a prepaid health plan shall meet the standards required pursuant to the provisions 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), standards specifically required by federal law, and the following requirements:

(1) Each prepaid health plan shall establish a grievance procedure under which enrollees may submit their grievances. The procedure shall be approved by the department prior to the approval of the contract. The department shall establish standards for the procedures to insure adequate consideration and rectification of enrollee grievances. A prepaid health plan shall make a finding of fact in the case of each grievance processed, a copy of which shall be transmitted to the enrollee. If the enrollee has an unresolved grievance, the fair hearing provided in Chapter 7 (commencing with Section 10950) of Part 2 shall be available to resolve all grievances regarding care and administration by the prepaid health plan. The findings and recommendations of the department, based on the decision of the hearing officer, shall be binding upon the prepaid health plan. Any changes in a proposed health plan's grievance procedure must be approved by the department before the changes take effect.

(2) (A) Medi-Cal enrollees shall have the same responsibilities and shall be entitled to the same rights as other enrollees with regard to any requirements for arbitration as a condition of membership in a health plan.

(B) Arbitration requirements shall be clearly disclosed in all of the contractor's Medi-Cal marketing presentations, materials and brochures, enrollment agreements, evidence of coverage, and disclosure forms.

(3) The prepaid health plan shall provide the director, for their approval, a plan for marketing its services to Medi-Cal beneficiaries which relates the proposed service to the need for services, and the size of the potential population to be served in the proposed service area.

(4) The prepaid health plan shall demonstrate to the department that it has adequate financial resources, administrative abilities and soundness of program design to carry out its contractual obligations.

(b) The requirements of this section shall apply to all managed care plan contracts entered into under any of the following:

(1) The act that added this subdivision.

(2) Any of the following provisions of Chapter 7 (commencing with Section 14000).

(A) Article 2.7 (commencing with Section 14087.3).

(B) Article 2.9 (commencing with Section 14088).

(C) Article 2.91 (commencing with Section 14490).

(3) Article 7 of Chapter 8 (commencing with Section 14490).

SEC. 5. Section 14452 of the Welfare and Institutions Code is amended to read:

14452. (a) (1) All subcontracts shall be entered into pursuant to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 and federal law. All subcontracts shall be in writing, a copy of which shall be transmitted to the department.

(2) Each subcontract shall contain the amount of compensation or other consideration that the subcontractor will receive under the terms of the subcontract with the prepaid health plans. These provisions shall not apply to a provider who is employed or salaried by the prepaid health plan. Unless the department objects, a prepaid health plan may enter into a subcontract in which consideration is determined by a percentage of the primary contractor's payment from the department. This subdivision shall not be construed to prohibit any subcontract in which consideration is determined on a capitation basis.

(3) Subcontracts between a prepaid health plan and the subcontractor shall be public records on file with the department. The names of the officers and owners of the subcontractor, stockholders owning more than 10 percent of the stock issued by the subcontractor, and major creditors holding more than 5 percent of the debt of the subcontractor shall be submitted by each prepaid health plan to the department and shall be public records on file with the department.

(b) A prepaid health plan that is not a qualified health maintenance organization pursuant to Title XIII of the federal Public Health Service Act shall submit all provider and management subcontracts to the department for approval prior to the subcontract taking effect.

(c) Each subcontract shall require that the subcontractor make all of its books and records pertaining to the goods and services furnished under the terms of the subcontract available for inspection, examination, or copying by the department during normal working hours at the subcontractor's place of business, or another mutually agreeable location in California.

SEC. 6. Section 14457 of the Welfare and Institutions Code is amended to read:

14457. (a) In addition to the reviews required or authorized by Section 14456, the department shall conduct periodic onsite visits or additional visits after a determination by the director of good cause by departmental representatives to include observation of the general operation of the prepaid health plan, the condition of the facilities for delivering health care, the availability of emergency services, the degree of satisfaction of the enrollees, the operation of the plan's grievance system, and the administrative and financial aspects of the operation of the prepaid health plan.

(b) Except when reviewing a plan's grievance system or marketing activities, this evaluation shall use standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975. Except in those instances where major, unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the visits shall be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, if reviews under that act will be carried out within time periods that satisfy the requirements of federal law.

(c) The State Department of Health Services may contract with the Department of Managed Health Care to perform the periodic visits required by this section.

SEC. 7. Section 14459 of the Welfare and Institutions Code is amended to read:

14459. (a) The prepaid health plan shall maintain financial records and shall have an annual audit or additional audits after a determination by the director of good cause, performed by an independent certified public accountant. A prepaid health plan operated by a public entity shall have an annual audit performed in a manner approved by the department. All certified financial statements shall be filed with the department as soon as practical after the end of the prepaid health plan's fiscal year and in any

event, within a period not to exceed 90 days thereafter. These financial statements shall be filed with the department and shall be public records. The department shall perform routine auditing of prepaid health plan contractors and their affiliated subcontractors. Except in those instances where major unanticipated obstacles prevent, or after a determination by the director of good cause, the audits shall be scheduled and carried out jointly with audits carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, if audits under that act are carried out within time periods that satisfy the requirements of federal law. The department is authorized to contract with the Department of Managed Health Care to carry out the audits required by this section. The prepaid health plan shall make all of its books and records available for inspection, examination, or copying by the department during normal working hours at the prepaid health plan's principal place of business or at such other place in California as the department shall designate. For good cause, the department may grant an exception to the time when annual financial statements are to be submitted to the department. The annual report required in Section 14313 shall include an itemization of expenditures made by each prepaid health plan for the following categories of expenditures: physician services, inpatient and outpatient hospital services, pharmaceutical services and prescription drugs, dental services, medical transportation services, vision care services, mental health services, laboratory services, X-ray services, enrollee education programs, marketing and enrollment costs, data-processing costs, other administrative costs and health service expenditures and any payments made to subcontractors, and the purposes of the payments, including, but not limited to, contributions to election campaigns.

(b) The requirements of a financial and administrative review by the department of any health care service plan licensed by the Director of the Department of Managed Health Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code may be waived upon submission of the financial audit for the same period conducted by the Department of Managed Health Care pursuant to Section 1382 of the Health and Safety Code.

SEC. 8. The heading of Chapter 3 (commencing with Section 15850) of Part 3.3 of Division 9 of the Welfare and Institutions Code is amended to read:

CHAPTER 3. County Children's Health Initiative Program

SEC. 9. Section 15850 of the Welfare and Institutions Code is amended to read:

15850. This chapter shall be known, and may be cited, as the County Children's Health Initiative Program (CCHIP).

SEC. 10. Section 15850.1 of the Welfare and Institutions Code is amended to read:

15850.1. For purposes of this chapter, the following definitions shall apply:

(a) "Administrative costs" means those expenses that are described in Section 1397ee(a)(1)(D) of Title 42 of the United States Code.

(b) "Applicant" means a county, county agency, a local initiative, or a county organized health system.

(c) "Department" means the State Department of Health Care Services.

(d) "Child" means a person under 19 years of age.

(e) "Comprehensive health insurance coverage" means the coverage provided in Section 2103 of the Social Security Act (42 U.S.C. Sec. 1397cc) and shall be equivalent to the coverage provided to state employees through the Public Employees' Retirement System for the most recent plan year preceding the applicable program plan year, except that the plans may provide a mechanism for inpatient hospital care provided under the mental health benefit through which applicants may agree to a treatment plan in which each inpatient day may be substituted for two residential treatment days or three day treatment program days.

(f) "County Children's Health Initiative Program" or "CCHIP" means the program established pursuant to this chapter.

(g) "County organized health system" means a health system implemented pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3 of this division and Article 1 (commencing with Section 101675) of Chapter 3 of Part 4 of Division 101 of the Health and Safety Code.

(h) "Fund" means the County Health Initiative Matching Fund.

(i) "Local initiative" means a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries. The entities established pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96 are local initiatives.

(j) "Optional targeted low-income children group" means the population described in Section 1905(u)(2)(B) of the Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)) and in Section 14005.26.

(k) "Access program" means the Medi-Cal Access Program under Chapter 2 (commencing with Section 15810).

(l) "Health care service plan" includes Medi-Cal managed care plans contracting with the department under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3.

SEC. 11. Section 15850.5 of the Welfare and Institutions Code is amended to read:

15850.5. (a) Notwithstanding any other law, except as provided in subdivision (b), each applicant who was participating in CCHIP, formerly known as the County Health Initiative Matching Fund, on March 23, 2010, pursuant to former Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, shall participate in the program established by this chapter, maintaining eligibility standards, methodologies, and procedures at least as favorable to eligible individuals as those in effect on March 23, 2010, and in a manner that satisfies the maintenance of effort obligation established in Section 2105(d)(3) of the Social Security Act (42 U.S.C. Sec. 1397ee(d)(3)).

(b) (1) If an applicant county participating in CCHIP, formerly known as the County Health Initiative Matching Fund, on March 23, 2010, elects to cease funding the nonfederal share of program expenditures made pursuant to Section 15852, the department shall administer the program within that applicant county consistent with subdivision (a).

(2) Notwithstanding any other law, the state general fund shall provide funding amounts equal to the total nonfederal share of all expenditures incurred by the department pursuant to paragraph (1).

(3) The nonfederal share amounts described in paragraph (2) shall be deposited in the County Health Initiative Matching Fund created pursuant to Section 15852, and those funds shall be used by the department for purposes otherwise consistent with that section.

(c) Notwithstanding any other law, as of the enactment of this section, the department shall not approve any additional applicant for participation under this chapter other than those applicants participating as of March 23, 2010.

(d) This section shall only be operative to extent that federal financial participation is not jeopardized and any necessary federal approvals are secured.

(e) This section shall become inoperative on the date that the maintenance of effort obligation pursuant to Section 2105(d)(3) of the Social Security Act (42 U.S.C. Sec. 1397ee(d)(3)) is no longer applicable to the state for purposes of this chapter.