An act to amend Section 14094.4, 14094.5, 14094.6, and 14184.200 of the Welfare and Institutions Code, relating to Medi-Cal.

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. Commencing no sooner than January 1, 2025, a "Medi-Cal managed care plan" shall also include a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5).

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

14094.5. (a) 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.

(b) No sooner than January 1, 2024, 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 in the following counties: Colusa, Glenn, Nevada, Plumas, Sierra, Sutter, Tehama, Yuba, Mariposa and San Benito.

(c) No sooner than January 1, 2025, 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, Regional Health Authority, or a Single Plan model, in the following counties: Alameda, Butte, Contra Costa, Imperial and Placer.

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~~ system, Regional Health Authority, or a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5), 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 14184.200 of the Welfare and Institutions Code is amended to read:

14184.200. (a) Notwithstanding any other law, the department may standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with the CalAIM Terms and Conditions and as described in this section.

(1) (A) The department shall ensure the Medi-Cal managed care plan's readiness for network adequacy includes a geographic access review of rural ZIP Codes to ensure time or distance standards are met, or alternative access standard requests are approved, as applicable, and the plan's ability to meet existing federal and state mandatory provider type requirements, where available.

(B) The department shall not require a population to enroll in managed care if Medi-Cal managed care plans fail to meet the Medi-Cal managed care plan readiness requirements detailed in this paragraph for that population.

(2) The Medi-Cal managed care plan shall comply with the continuity of care requirements in Section 1373.96 of the Health Safety Code and shall be consistent with and no more restrictive than existing policy and guidance, including All Plan Letter 18-008 and Duals Plan Letter 16-002.

(3) The disenrollment process for an enrollee in any county shall be consistent with and no more restrictive than existing federal and state statutes and regulations, including Section 53889 and subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. The beneficiary may request a medical exemption

from mandatory enrollment in a Medi-Cal managed care plan in accordance with Section 53887 of Title 22 of the California Code of Regulations and may disenroll or be exempted from mandatory enrollment under the limited circumstances set forth in subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. That disenrollment or exemption from mandatory enrollment in a Medi-Cal managed care plan shall be consistent with subsection (c) of Section 438.56 of Title 42 of the Code of Federal Regulations and applicable state law.

(b) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a non-dual-eligible beneficiary, except a beneficiary identified in paragraph (2), shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the following dual and non-dual beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in a Medi-Cal managed care plan:

(A) A beneficiary eligible for only restricted-scope Medi-Cal benefits, as described in subdivision (d) of Section 14007.5.

(B) A beneficiary made eligible on the basis of a share of cost, including, but not limited to, a non-dual-eligible beneficiary residing in a county that is authorized to operate a county organized health system (COHS), as described in Article 2.8 (commencing with Section 14087.5), except for a non-dual-eligible beneficiary that is eligible on the basis of their need for long-term care services with a share of cost, as identified by the department.

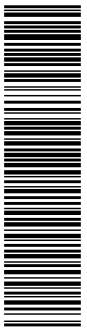
(C) A beneficiary made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, as determined by the department, but only during the relevant period of presumptive eligibility.

(D) An eligible beneficiary who is an inmate of a public institution, or who is released pursuant to Section 26605.6 or 26605.7 of the Government Code.

(E) A beneficiary with satisfactory immigration status, including a noncitizen that is lawfully present, who is eligible for only pregnancy-related Medi-Cal coverage and who received services through the Medi-Cal fee-for-service delivery system prior to January 1, 2022, as identified by the department, but only through the end of the postpartum period.

(F) A beneficiary without satisfactory immigration status or who is unable to establish satisfactory immigration status as required by Section 14011.2, who is eligible for only pregnancy-related Medi-Cal coverage, excluding a beneficiary enrolled in the Medi-Cal Access Program described in Chapter 2 (commencing Section 15810) of Part 3.3.

(G) A non-dual-eligible beneficiary who is an Indian, as defined in subdivision (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.



(H) A non-dual-eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a non-dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section ~~14087.5).~~ 14087.5), or in a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5).

(I) A non-dual-eligible beneficiary enrolled with an entity with a contract with the department pursuant to the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591).

(J) Any other non-dual-eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(K) A beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(c) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2023, and subject to subdivision (f) of Section 14184.102, a dual eligible beneficiary, except as provided in paragraph (2) of subdivision (b) or paragraph (2) of this subdivision, shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) The following dual eligible beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in Medi-Cal managed care as described in paragraph (1):

(A) A dual eligible beneficiary made eligible on the basis of a share of cost, including, but not limited to, a dual eligible beneficiary residing in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), except for a dual eligible beneficiary who is eligible on the basis of their need for long-term care services with a share of cost, as determined by the department.

(B) A dual eligible beneficiary enrolled with an entity with a contract with the department pursuant to PACE as described in Chapter 8.75 (commencing with Section 14591).

(C) A dual eligible beneficiary enrolled with an entity with a Senior Care Action Network (SCAN) contract with the department.

(D) A dual eligible beneficiary who is an Indian, as defined in subsection (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(E) A dual eligible beneficiary with HIV/AIDS who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(F) A dual eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section ~~14087.5).~~ 14087.5), or in a county operating a Single Plan model of managed care established

under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5).

(G) A dual eligible beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(H) Any other dual eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(d) (1) This section shall not prohibit a Medi-Cal beneficiary from receiving covered benefits on a temporary basis through the Medi-Cal fee-for-service delivery system pending enrollment into an individual Medi-Cal managed care plan in accordance with this section and the CalAIM Terms and Conditions.

(2) This section shall not prohibit certain Medi-Cal beneficiaries eligible for full-scope benefits under the Medi-Cal State plan, as identified by the department, from voluntarily enrolling in a Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(e) (1) No later than January 1, 2023, in all non-County Organized Health System counties, in areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in enrollment materials, and made available to an applicable beneficiary whenever enrollment choices and options are presented. Outreach and enrollment materials shall enable a Medi-Cal beneficiary to understand what PACE provides, that, if eligible, they may be assessed for PACE eligibility and enroll in PACE, and how they can receive additional information and request to be assessed for PACE eligibility. A person meeting the age qualifications for PACE and who chooses PACE shall not be assigned to a Medi-Cal managed care plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for PACE. A person enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE plan pursuant to the three-way agreement between the PACE plan, the department, and the federal Centers for Medicare and Medicaid Services.

(2) In areas of the state where a presentation on Medi-Cal managed care plan enrollment options is unavailable, the department, or its contracted vendor, shall provide informational, outreach, and enrollment materials about the PACE program.

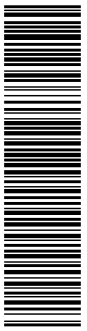
(f) For purposes of this section, the following definitions apply:

(1) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this article, "dual eligible beneficiary" shall include both a "full-benefit dual eligible beneficiary" and a "partial-benefit dual eligible beneficiary," as those terms are defined in this subdivision.

(2) "Full-benefit dual eligible beneficiary" means an individual 21 years or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(3) "Non-dual-eligible beneficiary" means an individual eligible for medical assistance under the Medi-Cal State plan, as determined by the department, that is not eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

(4) “Partial-benefit dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan.



LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Medi-Cal: managed care plans.

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.

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. Existing law, commencing no sooner than January 1, 2024, expands managed care plans under the Whole Child Model program to also include an alternate health care service plan (AHCSP).

This bill would, among other things, commencing no sooner than January 1, 2025, expand managed care plans under the Whole Child Model program to also include a county operating a Single Plan model of managed care, as specified. This bill, no sooner than January 1, 2024, or January 1, 2025, would expand the above-described authorization to establish a Whole Child Model program to additional counties, as specified.

Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts dual and non-dual beneficiary groups from that mandatory enrollment, including, among others, non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, but excludes from that exemption, those who reside in a county that is authorized to operate a county organized health system.

This bill would additionally exclude those non-dual-eligible beneficiaries who reside in a county operating a Single Plan model of managed care from that exemption, thereby subjecting that population to mandatory enrollment in a Medi-Cal managed care plan.

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