AMENDED IN ASSEMBLY APRIL 21, 2014

AMENDED IN ASSEMBLY MARCH 25, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1759

Introduced by Assembly Members Pan and Skinner (Coauthor: Assembly Member Bonta)

February 14, 2014

An act to add Sections 14105.196 and 14105.197 to the Welfare and Institutions Code, relating to health care services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1759, as amended, Pan. Medi-Cal: reimbursement rates.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing federal law requires the state to provide payment for primary care services furnished in the 2013 and 2014 calendar years by Medi-Cal providers with specified primary specialty designations at a rate not less than 100% of the payment rate that applies to those services and physicians under the Medicare Program.

Existing state law requires, to the extent required by federal law, and beginning January 1, 2013, through and including December 31, 2014, that payments for primary care services provided by specified physicians be no less than 100% of the payment rate that applies to those services and physicians as established by the Medicare Program, for both fee-for-service and managed care plans.

This bill would require that those payments continue indefinitely to the extent permitted by federal law but only to the extent that federal financial participation is available and would also require that those payments be made to other providers identified in federal law as eligible for the increased reimbursement. The bill would authorize the department to implement these provisions through provider bulletins without taking regulatory action until regulations are adopted and would require the department to adopt those regulations by July 1, 2017. The bill also *would request the University of California to annually conduct an independent assessment of Medi-Cal provider reimbursement rates and* would require the department to annually review the findings and recommendations of ~~an independent assessment of Medi-Cal provider reimbursement rates and to~~ *that assessment and* suggest adjustments to the reimbursement rates as necessary to ensure that quality and access in the Medi-Cal fee-for-service program and in Medi-Cal managed care plans are adequate to meet applicable state and federal standards. The bill would require that the findings and recommendations of the independent assessment and the director's suggested adjustments to provider reimbursement rates be submitted to the Legislature annually as part of the Governor's Budget. *The bill would also create an advisory committee composed of 16 members appointed by the Governor and the Legislature, as specified, to meet periodically with the University of California and provide input on the assessment conducted pursuant to the bill's provisions.*

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. Section 14105.196 is added to the Welfare and Institutions Code, to read:

14105.196. (a) It is the intent of the Legislature to maintain the increased reimbursement rates for primary care providers in the Medi-Cal program upon expiration of the temporary increase provided for under Chapter 23 of the Statutes of 2012, as amended by Chapter 438 of the Statutes of 2012, in order to ensure adequate access to these providers. It is also the intent of the Legislature to provide a mechanism to increase reimbursement rates for other Medi-Cal providers in order to comply with federal Medicaid requirements that care and services are available to Medi-Cal

enrollees at least to the extent that care and services are available to the general population in the geographic area.

(b) Beginning January 1, 2015, to the extent permitted by federal law and regulations, payments for primary care services provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine shall not be less than 100 percent of the payment rate that applies to those services and physicians as established by the Medicare Program, for both fee-for-service and managed care plans.

(c) (1) To the extent required by federal law or regulation, beginning January 1, 2015, through and including the date specified in that federal law or regulation, payments for primary care services provided by a provider other than a physician shall not be less than 100 percent of the payment rate that applies to those services and providers as established by the Medicare Program, for both fee-for-service and managed care plans.

(2) To the extent permitted by federal law and regulation, the payments to the providers identified in paragraph (1) shall continue indefinitely.

(d) Notwithstanding any other law, to the extent permitted by federal law and regulations, the payments for primary care services made pursuant to this section shall be exempt from the payment reductions under Sections 14105.191 and 14105.192.

(e) Payment increases made pursuant to this section shall not apply to provider rates of payment described in Section 14105.18 for services provided to individuals not eligible for Medi-Cal or the Family Planning, Access, Care, and Treatment (Family PACT) Program.

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

(1) "Primary care services" and "primary specialty" means the services and primary specialties defined in Section 1202 of the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152; 42 U.S.C. Sec. 1396a(a)(13)(C)), and any amendments to that section, and related federal regulations.

(2) "A provider other than a physician" means a health care provider, other than a physician, who is identified in federal law or regulation as eligible for payments for primary care services rendered under the federal Medicaid program at a rate not less than

100 percent of the payment rate that applies to those services as established by the Medicare Program.

(g) Notwithstanding any other law, the payment increase implemented pursuant to this section shall apply to managed care health plans that contract with the department pursuant to Chapter 8.75 (commencing with Section 14591) and to contracts with the Senior Care Action Network and the AIDS Healthcare Foundation, and to the extent that the services are provided through any of these contracts, payments shall be increased by the actuarial equivalent amount of the payment increases pursuant to contract amendments or change orders effective on or after January 1, 2015.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, clarify, make specific, and define the provisions of this section by means of provider bulletins or similar instructions, without taking regulatory action until the time regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning July 1, 2015, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report regarding this section to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(i) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 2. Section 14105.197 is added to the Welfare and Institutions Code, to read:

14105.197. *(a) The Legislature requests the University of California to annually conduct an independent assessment of Medi-Cal provider reimbursement rates.*

(b) (1) An advisory committee is hereby created to be composed of 16 members representing health care stakeholders, including, but not limited to, patients, providers, public and private health delivery systems, payers, and state officials. The Governor shall appoint eight members, the Senate Committee on Rules shall appoint four members, and the Speaker of the Assembly shall appoint four members.

(2) Except for the initial appointments described in paragraph (3), members of the committee shall be appointed for a term of four years, and each member shall hold office until the appointment and qualification of his or her successor or until one year has elapsed since the expiration of the term for which he or she was appointed, whichever occurs first.

(3) (A) Of the initial members appointed by the Governor, two shall serve a term of one year, two shall serve a term of two years, two shall serve a term of three years, and two shall serve a term of four years.

(B) Of the initial members appointed by the Senate Committee on Rules, one shall serve a term of one year, one shall serve a term of two years, one shall serve a term of three years, and one shall serve a term of four years.

(C) Of the initial members appointed by the Speaker of the Assembly, one shall serve a term of one year, one shall serve a term of two years, one shall serve a term of three years, and one shall serve a term of four years.

(4) Members of the committee shall publicly report financial and other potential conflicts of interest.

(5) The committee shall establish an open process for the conduct of its affairs that enables all health care stakeholders to provide feedback on those affairs.

(6) The committee shall meet periodically with the University of California and provide input to the University of California on the assessment conducted pursuant to subdivision (a).

(c) The director shall annually review the findings and recommendations of ~~an independent assessment of Medi-Cal provider reimbursement rates~~ *the assessment conducted under subdivision (a)* and suggest adjustments to the reimbursement rates as necessary to ensure that quality and access in the Medi-Cal fee-for-service program and in Medi-Cal managed care plans are adequate to meet applicable state and federal standards. ~~Notwithstanding~~

(d) Notwithstanding Section 10231.5 of the Government Code, the findings and recommendations of the independent assessment *conducted under subdivision (a)* and the director's suggested adjustments to provider reimbursement rates *provided pursuant to subdivision (c)* shall be submitted to the Legislature annually

as part of the Governor's Budget submitted pursuant to Section 13337 of the Government Code.

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