ASSEMBLY BILL No. 1759

Introduced by Assembly Member Pan

February 14, 2014

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1759, as introduced, 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. The bill would authorize the department to implement those 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 require the department to annually review the findings and recommendations of an independent assessment of Medi-Cal provider reimbursement rates and to 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.

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 the 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) (1) 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.

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

(3) Payment increases made pursuant to this subdivision 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.

(4) For purposes of this subdivision, "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 related federal regulations.

(5) Notwithstanding any other law, the payment increase implemented pursuant to this subdivision 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.

(6) 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 subdivision 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 to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

(c) The director shall annually review the findings and recommendations of an independent assessment of Medi-Cal provider reimbursement rates 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 Section 10231.5 of the Government Code, the findings and recommendations of the independent assessment and the director's suggested adjustments to provider reimbursement rates 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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