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# Legislation Implementation Seminar

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# Political Update

## Health Care Reform



# Legislative Overview

## • **Victories- Defeated Bills**

### CAHP Opposed Legislation

- AB 1554 (Jones) Rate Regulation- FAILED
- SB 1522 (Steinberg) Individual Market- FAILED
- AB 2967 (Lieber) Transparency- FAILED
- AB 2549 (Hayashi) Rescission- FAILED
- AB 2910 (Huffman) KK Waivers- FAILED
- AB 2847 (Krekorian) Litigation- FAILED
- AB 2839 (Huffman) Providers Bill of Rights- FAILED
- AB 2805 (Ma) Assignment of Benefits- FAILED



# Legislative Overview

- **CAHP Veto Victories**

- AB 30 (Evans) Inborn Errors of Metabolism Mandate
- AB 16 (Evans) HPV Vaccines Mandate
- AB 54 (Dymally) Acupuncture Mandate
- AB 368 (Carter) Hearing Aids Mandate
- AB 1887 (Beall) DSM IV Mandate
- AB 1945 (De La Torre) Rescission
- AB 2220 (Jones) Mediation
- SB 840 (Kuehl) Single Payer
- SB 981 (Perata) Balance Billing
- SB 1198 (Kuehl) DME Mandate to Offer
- SB 1440 (Kuehl) Medical Loss Ratio
- SB 1563 (Perata) Autism Workgroup
- SB 1634 (Steinberg) Cleft Palates Mandate



# Legislative Overview

- Unions
- Doctors Agenda
- Balance Billing Battles



# Legislative Overview

- **Big Picture for Health Plans**
  - Narrowly Avoided Disaster
  - Medi-Cal Budget Developments



# Implementation Guidelines

- AB 1150 (Lieu) Employee Compensation
- AB 1203 (Salas) Hospital Care
- AB 1894 (Krekorian) HIV Testing
- AB 2569 (De Leon) Rescission
- AB 2589 (Solorio) Broker Disclosures
- SB 697 (Yee) Balance Billing
- SB 1168 (Runner) Dependent Coverage
- SB 1379 (Ducheny) Fines and Penalties
- SB 1387 (Padilla) Dental Plans
- SB 1406 (Correa) Scope of Practice
- SB 1553 (Lowenthal) Mental Health



# **AB 1150 (Lieu)**

Prohibits employee compensation based on rescissions, cancellations, etc.

## **BACKGROUND**



# **AB 1150 (Lieu)**

## **Employee Compensation**

- **Requirements**

- Prohibits plans from basing employee compensation on the number of contracts that the person or entity has caused or recommended to be rescinded, canceled, or limited, or the resulting cost savings to the health plan.



# AB 1150 (Lieu)

## Employee Compensation

- **Implementation Suggestions**

Review existing practices, policies and procedures to ensure than plan operations do not do either of the following:

- 1) Base compensation on the number of contract rescissions, cancellations or limitations, or the resulting cost savings
- 2) Base compensation, or set performance goals or quotas on the number of persons whose coverage is rescinded or financial savings association with such rescission.



# AB 1150 (Lieu)

## Employee Compensation

- **Implementation Suggestions**

*Where Needed:*

- 1) Review and Amend

- Policies and Procedures
- Job Descriptions
- Employee goals

- 2) Create a specific policy to state that compensation, goals and quotas will not be based on contract rescissions.



# **AB 1203 (Salas)**

Bans balance billing of enrollees by non-contracting hospitals that fail to make specified contact with health plans

## **BACKGROUND**



# **AB 1203 (Salas)**

## **Poststabilization Care**

- **Requirements (Hospitals)**

- Provides that a non-contracting hospital shall not bill a patient who is an enrollee of a health plan, except for copayments, coinsurance, and deductibles, unless;
  - The patient or patient's spouse or guardian refuses transfer.
  - The hospital is unable to obtain the name and contact information of the health plan.
- Requires a noncontracting hospital, prior to providing post-stabilization care to a plan enrollee to do the following upon stabilization;
  - Seek to obtain the name and contact information of the health plan and document its attempts.
  - Contact the patient's health plan, or the plan's contracting medical provider, for authorization to provide post-stabilization.



# **AB 1203 (Salas)**

## **Poststabilization Care**

- **Requirements (Hospitals)**

- Requires non-contracting hospital to provide to the plan upon request the diagnosis and other relevant information necessary to make a decision to authorize post-stabilization care.
- Requires non-contracting hospitals to request a patient's medical record from the patient's health plan or its contracting medical provider if authorization for post-stabilization care has been granted.



# **AB 1203 (Salas)**

## **Poststabilization Care**

- **Requirements (Health Plans)**

- Requires a health plan or its contracting medical provider that requires prior authorization for post-stabilization care, to provide access for patients and providers, including non-contracting hospitals, to obtain authorization for post-stabilization care.
- Requires health plans to provide all non-contracting hospitals with the specific contact information necessary to make the contact required by this bill, to be updated as necessary but no less than once a year.
- Requires health plans to provide the contact information to the DMHC to post on its web-site no later than January 1 of each year.



# **AB 1203 (Salas)**

## **Poststabilization Care**

- **Requirements (Health Plans)**

- Requires a health plan or its contracting provider to respond to a request for authorization for post-stabilization care within 30 minutes of the initial contact by authorizing the care or informing the non-contracting hospital that it will arrange for transfer.
- If the health plan or contracting medical provider does not respond within 30 minutes then the post-stabilization care is authorized. If the plan or contracting provider notified the non-contracting hospital that it is assuming management of the patient but fails to affect a transfer in a reasonable time than it shall pay charges according to Knox-Keene and any regulations until the transfer takes place.



# **AB 1203 (Salas)**

## **Poststabilization Care**

- **Requirements (Health Plans)**

- Requires a health plan, or its contracting medical provider, if it decides to assume management of the patient's care by prompt transfer to do the following;
  - Arrange and pay the reasonable charges associated with the transfer of the patient.
  - Pay for all of the immediately required medically necessary care rendered to the patient prior to the transfer.
  - Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding a contracted facility available for the transfer.
- Requires the health plan or its contracting medical provider, upon conferring with the hospital, to transmit any appropriate portion of the patient's medical record, if the records are in the plan's possession.



# AB 1203 (Salas)

## Poststabilization Care

- **Requirements (Other Provisions)**

- Makes certain requirements inapplicable to minor treatment procedures, if the procedure;
  - Is provided in the treatment area of the ED.
  - Concludes the treatment of the presenting emergency medical condition and is related to that condition, even though the treatment may not resolve the underlying condition.
  - Is performed according to accepted standards.
  - Results in the direct discharge or release of the patient from the ED following this care.
- States that nothing in this bill is intended to prevent a health plan or its contracting medical provider from assuming management of a patient's care after the initial provision of post-stabilization care by the non-contracting hospital before patient discharged.



# AB 1203 (Salas)

## Poststabilization Care

- **Implementation Suggestions**

Applies *only* to all health care service plans that require non-contracting hospitals to seek authorization for poststabilization care

Plans must annually provide the contact information needed to seek prior authorization for poststabilization care to all non-contracting hospitals and to the Department of Managed Health Care



# **AB 1203 (Salas)**

## **Poststabilization Care**

- **Implementation Suggestions**

Where needed:

- 1) Review and amend policies and procedures regarding authorization for emergency poststabilization care
- 2) Ensure there are processes in place to:
  - Respond within 30 minutes,
  - Obtain and provide medical records upon request
  - Accept and document refusal to transfer notices



# **AB 1894 (Krekorian)**

Mandates coverage of HIV testing

**BACKGROUND**



# **AB 1894 (Krekorain)**

## **HIV Testing Mandate**

- **Requirements**

- Requires every individual or group health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2009, that covers hospital, medical, or surgery expenses to provide coverage for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Provides, in the insurance code, that it shall remain within the sole discretion of the health insurer as to the provider of the testing with which it chooses to contract and that reimbursement shall be provided according to the respective principles and policies of the health insurer.



# AB 1894 (Krekorain)

## HIV Testing Mandate

- **Implementation Suggestions**

Where Needed:

- 1) Review and Amend policies and procedures that limit coverage for HIV testing related to primary diagnosis
- 2) Review and amend claims system edits
- 3) Consider implications of new law on emergency claims payment procedures for non-contracting providers. It may be impermissible to exclude HIV testing by a non-contracted provider in an emergency situation because the test is unrelated to the emergency.



# **AB 2569 (De Leon)**

Rescission

**BACKGROUND**



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Requirements**

- Requires every health plan that offers coverage in the individual market and rescinds that coverage to offer those covered, without medical underwriting, coverage that provides equal benefits without additional medical underwriting.
- A health plan may also permit an individual to remain covered under that plan contract with a revised premium rate that reflects the number of persons remaining on the contract.
- States that if an enrollee was subject to a preexisting condition provision or a waiting or an affiliation period under the individual plan contract that was rescinded, the health care service plan may apply the same preexisting condition provision or waiting or affiliation period in the new individual plan contract.



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Requirements (cont.)**

- Plans shall notify in writing all enrollees of the right to coverage under an individual plan contract pursuant to this section, at a minimum, when the plan rescinds the individual plan contract. The notice shall adequately inform enrollees of the right to coverage under this section.
- Establishes a duty for agents and brokers or representatives who assist an applicant in submitting an application to a health care service plan to ensure answers to health questions are accurate and complete.
- Requires agents and brokers, solicitors, solicitor firms or representatives who assist an applicant in submitting an application to a health care service plan to make a written attestation on the application.



# **AB 2569 (De Leon)**

## **Health Care Coverage: Rescission**

- **Implementation Suggestions**

Applicable to plans and insurers who provide individual coverage

Provides two broad requirements:

- 1) Continued Coverage of Certain Enrollees upon Rescission;  
and
- 2) Broker Attestations



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Implementation Suggestions**

- Coverage of Certain Enrollees

- Upon rescission of an individual contract, plans must offer enrollees whose information was not the subject of the rescission the ability to continue coverage (same or equal coverage) without medical underwriting.

- Plans must implement processes to notify enrollees of their ability to obtain this coverage, and to provide such coverage.

- Rates can be adjusted to reflect the number of people remaining on the contract.



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Implementation Suggestions**

### Broker Attestations

New requirements if agent, broker, solicitor, solicitor firm or representative assists an applicant in submitting an application for individual coverage.

Duty to assist applicant in providing accurate and complete answers and must make a written attestation on the application.

Application must contain the written attestation and a statement advising declarants of the civil penalty authorized for false statements.



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Implementation Suggestions**

### Broker Attestations

- 1) Ensure that agents, brokers, representatives are aware of these requirements (e.g. notice, training)
- 2) Applications for individual coverage must be modified to include a two-part attestation and a statement advising declarants of the civil penalty
- 3) Revised applications should be filed with the Department of Managed Health Care



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Implementation Suggestions**

- Broker Attestations

- Attestation must contain two elements:

- 1) to the best of the broker's knowledge the information is complete and accurate; and
    - 2) the broker explained to the applicant in easy-to-understand language, the risk to the applicant providing inaccurate information, and that the applicant understood the explanation.



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Implementation Suggestions**

- Broker Attestations

- Application must advise the declarant of the civil penalty

- Civil Penalty:

- If a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to \$10,000.



# AB 2569 (De Leon)

## Health Care Coverage: Rescission

- **Implementation Suggestions**

- Broker Attestations

Sample Attestation (there are many variations):

"I assisted the applicant in submitting this application. All information in the health questionnaire was completed by the applicant. I advised the applicant that h/she should answer all questions completely and truthfully and that no information on the application should be withheld. I explained that withholding information could result in the cancellation of coverage in the future. The applicant indicated to me that h/she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000."



## AB 2569 (De Leon)

- **Implementation Suggestions**

- Broker Attestations

Plans may also want to consider adding an attestation when brokers do not assist with the application. There is NO requirement to do so, but it could read something like this:

“I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.”



# **AB 2589 (Solorio)**

Disclosures: Agents and Brokers

**BACKGROUND**



# AB 2589 (Solorio)

## Disclosures: Brokers and Agents

### • Requirements

- A health care service plan shall annually disclose to the governing board of a public agency that is the subscriber of a group contract, the name and address of, and amount paid to, any agent, broker, or individual to whom the plan paid fees or commissions related to the public agency's group contract.
- Additionally, as part of this disclosure, the health care service plan shall include the name, address, and amounts paid to the specific agents, brokers, or individuals involved in transactions with the public agency.
- The compensation disclosure required by this section is in addition to any other compensation disclosure requirements that exist under law.



# AB 2589 (Solorio)

## Disclosures: Brokers and Agents

- **Implementation Suggestions**

Applies to plans and insurers that have a group contract with a public agency. A public agency is defined in Govt. Code Section 6500:

“Public agency includes, but is not limited to, the federal government or any federal department or agency, this state or any state department or agency, a county, county board of education, county superintendent of schools, city, public corporation, public district, regional transportation commission of this state or another state, or any joint powers authority formed pursuant to this article by any of these agencies.”



# AB 2589 (Solorio)

## Disclosures: Brokers and Agents

- **Implementation Suggestions**

NOTE: Plans may already collect broker commission information for Schedule A to IRS Form 5500

Where needed:

- Determine if and how information is currently being captured and stored
- Identify impacted departments
- Identify current contracted public agency groups
- Identify and track contact person for the governing board of each agency and document in system to ensure annual report will be received
- Develop written process to report required information
- Enhance database to enable annual reporting
- Create tracking system for annual notification
- Communicate new reporting requirements internally and to brokers



# **SB 697 (Yee)**

Prohibits the balance billing of  
HFP and AIM enrollees

**BACKGROUND**



# **SB 697 (Yee)**

## **Balance Billing: State Programs**

- **Requirements**

- Provides that a health care provider who is furnished documentation of a person's enrollment in the HFP or AIM program shall not seek reimbursement nor attempt to obtain payment for any covered services provided to that person other than from the participating health plan, except for applicable copayments.



# SB 697 (Yee)

## Balance Billing: State Programs

- **Implementation Suggestions**

Bill does not require that health care service plans take any action to implement the new statutes. However, plans may want to consider the possible, non-mandatory actions:

- Ensure that ID cards for AIM and Healthy Families members clearly identify those programs
- Notify contracting providers of the prohibition
- Consider adding an EOB message to payments to providers for HF and AIM members advising them that they cannot collect anything from the member for covered services other than copayments
- Notify customer service of the new law
- Create or modify cease and desist letters with citation



# **SB 1168 (Runner)**

Dependent Children

**BACKGROUND**



# SB 1168 (Runner)

## Health Coverage: Dependents

- **Requirements**

- SB 1168 applies to a plan that provides coverage for a dependent child who is over 18 years of age and enrolled as a full-time student at a secondary or postsecondary educational institution.
- If the dependent child takes a medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not render the child incapable of self-sustaining employment, the dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the plan, whichever comes first.
- The period of coverage under this law shall commence on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph.



# **SB 1168 (Runner)**

## **Health Coverage: Dependents**

- **Requirements (cont.)**
  - Documentation or certification of the medical necessity for a leave of absence from school shall be submitted to the plan at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school and shall be considered prima facie evidence of entitlement to coverage under this paragraph.



# **SB 1168 (Runner)**

## **Health Coverage: Dependents**

- **Implementation Suggestions**

Applies to plans and insurers that provide coverage for a dependent child who is over 18 years of age and enrolled as a full-time student. Specialized health care service plans and Medicare supplement plans are exempt from this statute.



# SB 1168 (Runner)

## Health Coverage: Dependents

- **Implementation Suggestions**

Where needed:

1. Review and amend language in the EOC relating to over-age dependents. Changes should be filed with the Department of Managed Health Care
2. Review and revise any other materials referring to over-age dependents
3. Modify existing internal policies and related manuals
4. Develop procedures to receive, process and respond to requests for leaves of absence coverage
5. Consider what notices, if any should be given to subscribers with students on their plans about their obligations if a medical leave of absence occurs.



# **SB 1168 (Runner)**

## **Health Coverage: Dependents**

- **Implementation Suggestions**

If the student's medical condition is such that he or she is disabled and incapable of self-sustaining employment, then h/she is eligible for continued coverage under the existing statutes related to over age disabled dependents

Students who lose coverage but who do not qualify for this extension, as well as those who exhaust the 12 months of leave of absence coverage, will still be eligible for COBRA, CalCOBRA, and other applicable extension of benefits.



# **SB 1168 (Runner)**

## **Health Coverage: Dependents**

- **Implementation Suggestions**

Congress passed HR 2851 which is expected to be signed by the president. HR 2851 is similar to AB 1168 but applies the coverage obligation to ASO accounts. HR 2851 is effective 12 months after it is signed and requires notices of leave of absence rights to be included when confirming student status for over-age dependents.



# **SB 1379 (Ducheny)**

Fines and Penalties

**BACKGROUND**



# **SB 1379 (Ducheny)**

## **Fines and Penalties**

- **Requirements**

- Prohibits the fines and penalties authorized under the Knox-Keene Act from being used to reduce assessments imposed on health plans.
- Requires, beginning September 1, 2009, the first \$1 million in fines and administrative penalties paid for violations of Knox-Keene to be transferred from the Fund to the Medically Underserved Account for Physicians (MUAP) within the Health Professions Education Foundation (Foundation).
- Requires fines and administrative penalties paid for violations of Knox-Keene in amounts over the first \$1 million, including accrued interest in the Fund, to be paid to the Major Risk Medical Insurance Fund.



# **SB 1379 (Ducheny)**

## Fines and Penalties

- **Implementation Suggestions**

SB 1379 was an urgency statute and went into effect immediately upon enactment on September 30, 2008

No specific implementation requirements have been identified.

However, plans may want to be vigilant in calculating enrollment, as there will be no refunds or reductions in assessments for miscalculation of enrollment by plans.



# **SB 1387 (Padilla)**

Dental Coverage: Overpayments

## **BACKGROUND**



# SB 1387 (Padilla)

## Dental Plans: Overpayments

- **Requirements**

- A Dental health care service plan's notice of overpayment shall inform the provider how to access the plan's dispute resolution mechanism offered pursuant to subdivision (h) of Section 1367.
- The plan notice of overpayment must also include the name and address to which the dispute should be submitted and a statement that Section 1371.1 requires a provider to reimburse the plan for an overpayment within 30 working days of receipt by the provider of the notice of overpayment unless the provider contests the overpayment within 30 working days.
- The plan notice of overpayment shall also include information clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.



# **SB 1387 (Padilla)**

## **Dental Plans: Overpayments**

- **Implementation Suggestions**

Applies to full service plans that offer dental benefits, specialized dental plans and insurers who offer dental benefits

Plans should revise their notice of overpayment to dental providers to include the requirements as just stated.



# **SB 1406 (Correa)**

Expands scope of practice in optometry

**BACKGROUND**



# **SB 1406 (Correa)**

## **Optometry: Scope of Practice**

- **Requirements**

- Specifies permissible procedures for certified optometrists, and creates the Glaucoma Diagnosis and Treatment Advisory Committee to establish glaucoma certification requirements.
- This is an expansion of the scope of practice for optometrists to allow them to treat the vast majority of glaucoma cases with the larger range of medicines and through nonsurgical procedures.



# **SB 1406 (Correa)**

## **Optometry: Scope of Practice**

- **Implementation Suggestions**

SB 1406 imposes no direct requirements on health care service plans but the bill could effect claims payment

Plans should review medical and claims policies and claims edits to ensure that anything relating to the scope of practice of an optometrist is modified to accommodate this change (denials as outside the scope of licensure for performance of the procedures in this bill)



# **SB 1553 (Lowenthal)**

Mental Health Services

**BACKGROUND**



# SB 1553 (Lowenthal)

## Mental Health Services

- **Requirements**

- Health plans that provide coverage for mental health services, and have a website, must include information to subscribers, enrollees, and providers that will assist subscribers and enrollees in accessing mental health services.
- Health plans providing mental health coverage may not approve, deny, or modify provider requests for mental health services based on:
  - Whether admission was voluntary or involuntary
  - The method of transportation to the health facility



# **SB 1553 (Lowenthal)**

## **Mental Health Services**

- **Implementation Suggestions**

Applies to health care service plans only.

Two new requirements on plans:

- 1) UM/Claims Payment
- 2) Plan websites



# **SB 1553 (Lowenthal)**

## **Mental Health Services**

- **Implementation Suggestions**

### **UM/Claims Payment**

**With respect to mental health services, plan medical necessity decisions to deny requests for authorization cannot be based on:**

- 1) Whether the admission was voluntary or involuntary; or**
- 2) The method of transportation to the health facility**



# **SB 1553 (Lowenthal)**

## **Mental Health Services**

- **Implementation Suggestions**

### **UM/Claims Payment**

- The restriction relates only to decisions to deny
- Plans may need to modify their UM policies to reflect the change



# **SB 1553 (Lowenthal)**

## **Mental Health Services**

- **Implementation Suggestions**

### **Plan Websites**

SB 1553 added a new requirement to the existing statute regarding plan websites. For plans that cover mental health services:

- “the Web site shall include, but not be limited to, providing information to subscribers, enrollees, and providers that will assist subscribers and enrollees in accessing mental health services.”

Note: the statute requires every health care service plan, except a plan that primarily serves Medi-Cal or Healthy Families Program enrollees, to maintain a website. Plans that are currently not required to have a website would not be required to comply.



# **SB 1553 (Lowenthal)**

## **Mental Health Services**

- **Implementation Suggestions**

### **Plan Websites**

- Plans may already have information that addresses this requirement. Plans should review their website information to make sure it contains information about how to access mental health services.



## **2008-2009 California State Budget**

- **AB 1781 – CHAPTER 268, STATUTES OF 2008  
State Budget**
- **AB 88 - CHAPTER 269, STATUTES of 2008  
Supplemental Budget Bill**
- **AB 1183 – CHAPTER 758, STATUTES of 2008  
Health Trailer Bill**



## 2008-2009 California State Budget

- **Requirements (Medi-Cal)**

- Restores on March 1, 2009 previously enacted reductions to Medi-Cal rates per the following:
  - Restores Fee-for-Service providers to a one percent rate cut.
  - Restores half of the 10 percent payment reductions to pharmacies (including both drug ingredient costs and the dispensing fee).
  - Restores half of the 10 percent rate cut to long-term care facilities that do not pay a quality assurance fee-primarily hospital-based (distinct part) long-term care and subacute facilities and adult day health care facilities.



## 2008-2009 California State Budget

- **Requirements (Medi-Cal)**

- Restores rates for Medi-Cal managed care plans on an actuarially equivalent basis with the fee-for-service rate restorations above.
- Includes \$169.8 million General Fund of rate increase funding for Medi-Cal managed care plans based on an annual actuarial analysis of cost and utilization trends. The administration proposed this funding and argued that it is the minimum needed to achieve federal matching funds for Medi-Cal managed care.



# 2008-2009 California State Budget

- **Requirements (Medi-Cal)**

- Includes language implementing the Rogers Amendment in Medi-Cal managed care to limit the rates for emergency care that Medi-Cal managed care plans must pay to hospitals that do not contract with the plan. The payment limit would be the lower of either 90 percent of the hospital cost-based rate or the regional average of the CMAC hospital contract rates (or tertiary hospital rate if appropriate). Specified small and rural hospitals are exempt.
- This trailer bill also specifies that for "post-stabilization" services following an emergency admission to a hospital, Medi-Cal payment amounts for these services will be adjusted as specified. These changes to non-contracting hospital payments in Medi-Cal managed care sunset as of January 1, 2011.



## 2008-2009 California State Budget

- **Requirements (Medi-Cal)**

- Alters enrollment reports for children in Medi-Cal to Semi-Annual reporting. This change sunsets as of January 1, 2012, unless a later statute is enacted.
- Requires the DHCS to provide County Organized Healthcare Systems with preliminary Medi-Cal managed care plan rates by no later than June 30 of each year, or if the budget is not passed by that date, within five working days of the annual Budget Act.



# 2008-2009 California State Budget

## • Requirements (HFP)

- Decreases, by five percent, rates paid to health, dental, and vision plans participating in the Healthy Families Program as the rate reduction will be effective the first day of the fifth month following enactment of the Budget Act of 2008.
- Increases the premiums in Healthy Families Program, commencing the first day of the fifth month following enactment of the budget, as follows:
  - Families with incomes of 150 percent to 200 percent of poverty will pay \$12 per child per month with a maximum contribution of \$36 per month per family.
  - Families with incomes above 200 percent of poverty will pay \$17 per child per month with a maximum contribution of \$51 per month per family.



## 2008-2009 California State Budget

- **Requirements (HFP)**

For families choosing the Family Value Package under the Healthy Families Program, premium adjustments are as follows:

Families with incomes of 150 percent to 200 percent of poverty will pay \$9 per child per month with a maximum contribution of \$27 per month per family.

Families with incomes above 200 percent of poverty will pay \$14 per child per month with a maximum contribution of \$42 per month per family.



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# Legislation Implementation Seminar

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**Nick Louizos, Legislative Advocate**  
**Gretchen Lachance, VP, Legal and  
Regulatory Affairs**  
**Brianna Hintze Director, Legal and  
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