STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

(916) 445-1912

January 9, 1981

To: All County Welfare Directors Letter No. 81-1

DUAL CHOICE PROGRAM

This letter informs you about the provisions of Senate Bill 1637, Chapter 1044, Statutes of 1980, and implementation plans developed by the Department of Health Services (DHS).

The legislation requires that to receive Medi-Cal benefits, all eligible recipients must choose between the regular fee-for-service Medi-Cal card and enrollment in a health maintenance organization (HMO) where this option is available. Further, Chapter 1044 requires the county to inform Medi-Cal recipients about their responsibility whenever eligibility is determined or redetermined. Currently, the only Medi-Cal beneficiaries eligible for HMO enrollment are Aid to Families with Dependent Children (AFDC) cash recipients, Supplemental Security Income/State Supplemental Payment (SSI/SSP) cash recipients, and medically needy persons linked to one of these cash programs who have zero share of cost for Medi-Cal and who reside within the service area of an HMO. Currently, the State contracts with HMOs in twelve counties; HMO contracts in two more counties may be signed in 1981.

Background

In the early 1970s, DHS began contracting with prepaid health plans (now called HMOs) to provide Medi-Cal benefits for eligible recipients. These plans used various marketing methods to enroll Medi-Cal eligibles. The most prevalent method was solicitation by plan enrollers who either went door-to-door in areas of known heavy concentrations of welfare recipients or who used a street-corner approach by waiting outside welfare offices for recipients. Solicitation became more aggressive and allegations of unethical tactics used to encourage enrollment were frequent.

DHS developed a number of monitoring mechanisms but it has been generally agreed that solicitation could not be monitored and should be replaced. The Legislature and Congress have enacted laws designed to identify workable alternatives to door-to-door solicitation.

In 1976, DHS designed the Prepaid Health Research, Evaluation and Demonstration (PHRED) Project funded by a federal grant to develop, among other things, alternatives to door-to-door solicitation. The most promising alternative tested by the PHRED Project is the presentation of a choice of health coverage in the welfare office. This choice very nearly approximates the situation whereby a new employee is offered a choice of company-paid health insurance plans as a part of the employee's benefit package. Chapter 1044 mandates the use of this alternative.

Implementation of this method, which is known as Dual Choice, has a high priority. Dual Choice will be phased in during the coming year in all counties with state HMO contracts.

Legislative Summary

Chapter 1044 (a copy is attached for your reference) amends Sections 14016.5 through 14016.8 of the Welfare and Institutions Code to mandate that when Medi-Cal eligibility is determined or redetermined, in areas where HMOs operate, the county must inform the Medi-Cal applicant or beneficiary about available methods to receive Medi-Cal. It also mandates that the Medi-Cal applicants or beneficiaries choose the method by which they desire to receive their Medi-Cal services.

Where the two options are available, the Medi-Cal client must make the choice in order to receive Medi-Cal. However, the law provides that clients receive a monthly fee-for-service card until they choose. Although this choice concept is new to the Medi-Cal sector, it is a long established practice in offering health care benefits to employee groups. The PHRED Project experience indicates that only a small fraction (much less than one percent) of the clients decline to make a choice.

Implementation

To fulfill the responsibilities of Chapter 1044, we have established the Dual Choice Unit within the Medi-Cal Eligibility Branch of the Health Care Policy and Standards Division. This Unit will develop and monitor the program, as well as assist and train the county staff during implementation. A copy of the proposed implementation schedule is attached. Of course, the schedule may be adjusted as time and circumstances warrant.

Initially, Dual Choice will offer only AFDC applicant/recipients who reside within the service area of a contracted HMO a choice between the monthly fee-for-service Medi-Cal card and enrollment in an HMO. Because HMO service areas may not correspond to the area served by a county district office, it is possible that not all county offices will be involved in Dual Choice.

If the applicant selects HMO enrollment and once the enrollment process is completed, no Medi-Cal card will be issued by DHS; instead, the HMO will issue an identification card, to be used at the HMO facilities for all Medi-Cal services. An HMO enrollee must use only the HMO facilities for Medi-Cal services. However, when recipients have an immediate medical need, and until the HMO enrollment process is completed, they will receive a regular Medi-Cal card. The recipient can use the card at the HMO facility or at any other facility which accepts Medi-Cal.

Of course, the other option for Medi-Cal eligibles is the regular monthly fee-for-service Medi-Cal card. As you know, the Medi-Cal card can be used at any provider or health facility where Medi-Cal is accepted, but the recipient is responsible for locating and choosing the provider.

The Dual Choice Unit is currently working on further program development in these components:

1. Presentation of Choice Information

   DHS will develop the method to inform applicants about their Medi-Cal options. Any presentation method must include available information from the fee-for-service sector as well as from the HMO. Marketing materials such as printed brochures, films, and exhibits such as flip charts may be used in the presentation. HMOs must develop and furnish specific marketing material about their operations. DHS will review HMO materials and edit them for accuracy, objectivity, and understandability. The necessary information must be presented fairly and objectively and clearly explain the choices to the Medi-Cal clients. A film is also available for county use to explain Dual Choice.

2. Development of Lists of Fee-For-Service Providers

   DHS will request from provider organizations a list of fee-for-service providers who are available to serve Medi-Cal eligibles in each area. If this information is obtained, the list will be available to clients during the Dual Choice presentation.

3. Training Materials

   DHS will train specialized county employees to perform the Dual Choice presentation.

4. Funding

   DHS has budgeted funds for the specialized county workers. Claiming will be through an adjunct report to the current claiming process.

5. Oversight of Implementation

   DHS will monitor the Dual Choice program to assure that the mandate of Chapter 1044 is met.

6. County Operated HMOs

   If the HMO is county administered, the duty to inform eligibles of their right to choose will either be performed by a state employee or by an independent contractor paid by DHS.

As we indicated earlier, the Dual Choice program is now offered only to AFDC clients, although we will eventually offer this to Medi-Cal eligibles in other aid categories.

We will advise you in subsequent All County Letters as we develop more specific information about Dual Choice implementation requirements. We will initiate contact with specific county welfare departments well in advance of any scheduled implementation date in those counties where the choice can be offered. Dual Choice Unit staff will meet with you and your designated representative to plan implementation in your county. In the meantime, if you have any concerns, you may contact Dual Choice staff at (916) 445-1912 or you may write to:

John Hanretty, Chief
Dual Choice Implementation Unit
Department of Health Services
714 P Street, Room 1676
Sacramento, CA 95814

Sincerely,

Original signed by

Barbara V. Carr, Acting Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Field Representatives
Prepaid Health Plans Branch
Expiration Date: July 31, 1981

Dual Choice Implementation Timetable

County	Date of Dual Choice Implementation
Alameda	Jul 80
San Francisco	Dec 80
San Diego	Feb 81
Santa Barbara	Feb 81
San Luis Obispo	Mar 81
Santa Clara	Jun 81
Los Angeles	Jun 81
Contra Costa	Jul 81
San Bernardino	Jul 81
Sacramento	Aug 81
Orange	Aug 81
Riverside	Oct 81
Yolo	Oct 81
San Mateo	Nov 81

Senate Bill No. 1637

CHAPTER 1044

An act to add Sections 14016.6, 14016.7, and 14016.8 to, and to repeal and add Section 14016.5 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 25, 1980. Filed with Secretary of State September 26, 1980.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1637, Garamendi. Medi-Cal: choice of benefits method.

Existing law requires the State Director of Health Services to direct the counties to inform Medi-Cal beneficiaries of the various methods for receiving Medi-Cal benefits, if they reside in an area served by a prepaid health plan and if they are eligible to enroll in such plan, and to inquire whether they wish to make a choice.

This bill would require, as a condition of coverage for Medi-Cal benefits, that a beneficiary or eligible applicant choose either to obtain benefits from an individual provider or to enroll in a prepaid health plan. Until a beneficiary or eligible applicant makes a choice, he or she would be provided with a monthly Medi-Cal card.

The State Department of Health Services would be required to develop a program as described to educate beneficiaries and eligible applicants to the choices available to them. County employees would carry out the program unless a county-sponsored prepaid health plan is offered, in which case the program would be carried out either by a specially trained state employee or by an independent contractor paid by the department. The programs in various counties would be phased in over a period of one year and would be operational no later than December 31, 1981.

The bill would provide for annual reports to the Legislature.

Under existing law, Sections 2231 and 2234 of the Revenue and Taxation Code require the state to reimburse local agencies and school districts for certain costs mandated by the state. Other provisions require the Department of Finance to review statutes disclaiming these costs and provide, in certain cases, for making claims to the State Board of Control for reimbursement. The statutory provisions requiring reimbursement will be supplemented by a constitutional requirement of reimbursement effective for statutes enacted on or after July 1, 1980.

This bill provides that no appropriation is made by this act pursuant to the constitutional mandate or Section 2231 or 2234, but recognizes that local agencies and school districts may pursue their other available remedies to seek reimbursement for these costs.

The people of the State of California do enact as follows:

SECTION 1. Section 14016.5 of the Welfare and Institutions Code is repealed.

SEC. 2. Section 14016.5 is added to the Welfare and Institutions Code, to read:

14016.5. (a) At the time of determining or redetermining the eligibility of a Medi-Cal applicant or beneficiary who resides in an area served by a prepaid health plan in which beneficiaries may enroll, the county shall inform the Medi-Cal applicant or beneficiary of options available regarding methods of receiving Medi-Cal benefits included in subdivisions (b) and (c).

(b) Each Medi-Cal beneficiary and eligible applicant shall, as a condition of coverage for Medi-Cal benefits, choose either of the following:

(1) To obtain benefits by receiving a monthly Medi-Cal card, which may be used to obtain services from individual providers who choose to provide services to Medi-Cal beneficiaries; or

(2) To obtain benefits by enrolling in a prepaid health plan contracting with the department to service Medi-Cal beneficiaries.

(c) Until such time as a Medi-Cal beneficiary or eligible applicant makes a choice, such person shall be provided with a monthly Medi-Cal card.

In areas where there is no prepaid health plan which has contracted with the department to provide services to Medi-Cal beneficiaries, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a monthly Medi-Cal card.

SEC. 3. Section 14016.6 is added to the Welfare and Institutions Code, to read:

14016.6. The State Department of Health Services shall develop a program to implement the provisions of Section 14016.5. The program shall include, but not be limited to, the following components:

(a) Development of a method to inform beneficiaries and applicants of their choices for receiving Medi-Cal benefits including the solicitation from representatives of the fee-for-service sector and from prepaid health plans, marketing materials including printed materials, films, and exhibits, to be provided to Medi-Cal beneficiaries and applicants when choosing methods of receiving health care benefits. The department shall not be responsible for the costs of developing this material.

The department may prescribe the format and edit such materials for factual accuracy, objectivity and comprehensibility. The department shall use such edited materials in informing beneficiaries and applicants of their choices for receiving Medi-Cal benefits.

(b) Provision of information that is necessary to implement this program in a manner that fairly and objectively explains to beneficiaries and applicants their choices for methods of receiving Medi-Cal benefits.

(c) Solicitation of and preparation of a list of providers who will provide services to Medi-Cal beneficiaries. Such lists shall be made available to Medi-Cal beneficiaries and applicants at the same time the beneficiary or applicant is being informed of the options available for receiving care.

(d) Training of specialized county employees to carry out the program.

(e) Monitoring the implementation of the program in those county welfare offices where choices are made available in order to assure that beneficiaries and applicants may make a well-informed choice, without duress.

If a county-sponsored prepaid health plan is offered, the responsibilities outlined in this section shall be carried out either by a specially trained state employee or by an independent contractor paid by the department.

SEC. 4. Section 14016.7 is added to the Welfare and Institutions Code, to read:

14016.7. The department shall establish a schedule which will allow for a phase-in of these programs in all county offices where a choice is made available to Medi-Cal beneficiaries and applicants pursuant to Sections 14016.5 and 14016.6. The phase-in shall be completed and all programs shall be operational no later than December 31, 1981.

SEC. 5. Section 14016.8 is added to the Welfare and Institutions Code, to read:

14016.8. The department shall incorporate in its annual report to the Legislature statistics reflecting the relative frequency with which each method of receiving Medi-Cal benefits pursuant to Sections 14016.5 and 14016.6 is chosen. The department shall annually conduct a survey to determine beneficiary satisfaction with the method of receiving Medi-Cal benefits, and the findings of the survey shall be incorporated in the department's annual report to the Legislature.

SEC. 6. Notwithstanding Section 2231 or 2234 of the Revenue and Taxation Code and Section 6 of Article XIII B of the California Constitution, no appropriation is made by this act pursuant to these sections. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Chapter 3 (commencing with Section 2201) of Part 4 of Division 1 of that code.

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