STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
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November 3, 1981

To: All County Welfare Directors

Letter No. 81-50

DRAFT AND PROMULGATE REGULATIONS TO IMPLEMENT SECTION 14016.5 ET SEQ., WELFARE AND INSTITUTIONS CODE

This letter is to inform you of our intent to draft and promulgate regulations to implement Section 14016.5 et seq., Welfare and Institutions Code (attached).

The provisions of the statute require certain counties to provide information regarding fee-for-service providers and health maintenance organizations to individuals whose eligibility for public assistance is being determined or redetermined. The Department of Health Services is responsible for developing the method to be used in such informing.

The Department of Health Services seeks your comments and concerns regarding this legislation. We have attached a draft set of regulations to implement the law. Please send any comments or suggestions by December 1, 1981 to:

John Hanretty
Medi-Cal Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95814

If you have any questions please contact your Medi-Cal Program Consultant.

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Amend 50012. Abbreviations.

The following abbreviations shall apply to Chapter 2 of this division.

(Add between HIC and INS) HMO. Health Maintenance Organization.

DRAFT

PRELINED DRAFT PAPER INDICATES AND IS TO BE USED ONLY FOR ALL NEW REGULATORY LANGUAGE.

50036.5. Dual Choice. Dual Choice means the provision of information regarding available health care options to clients who apply for the AFDC program or whose eligibility is redetermined for the AFDC program and the selection by the client of an option.

50101. County Department Responsibilities.

(a) (1) through (4) unchanged.

(5) "Assist applicants or beneficiaries in understanding their rights and responsibilities in relation to application for Medi-Cal" including the dual choice information where applicable.

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50105. Staffing Requirements.

(a) through (c) unchanged.

(d) Each County responsible for presenting the Medi-Cal dual choice information to applicants and beneficiaries shall assign a specially designated employee to serve as a Medi-Cal dual choice specialist.

50122. County of Responsibility -- Dual Choice Program.

The county of responsibility for operating a dual choice program is any county in which there is a prepaid health plan contract between a health maintenance organization and the Department of Health Services.

50142. Screening.

(a) County departments that have established a procedure for screening potential applicants prior to application shall:

(1) Determine the Medi-Cal program under which the person or family should be processed.

(2) Provide information regarding Medi-Cal eligibility requirements to all persons being screened.

(3) Inform each person being screened of that person's rights under the Medi-Cal program, even if it appears that the person is ineligible. Rights of persons requesting Medi-Cal, MC 216, shall be explained to, and signed by, the person being screened.

(A) The original shall be retained by the county department. If the person being screened does not apply for Medi-Cal, the form shall be retained for at least 90 days.

(B) A copy shall be given to the person being screened.

<u>(b) County departments which are required to offer dual choice shall provide written materials regarding available health care options to all persons who apply</u> *and appear to be eligible* <u>for the AFDC program.</u>

50157. Face-to-Face Interview.

(a) through (f) (5) unchanged.

~~(6) Availability of Medi-Cal prepaid health plans in the area.~~

(9) Applicant's or beneficiary's responsibilities as specified in Sections 50185 and 50187 which include but are not limited to:

(E) Requirement to attend a Medi-Cal dual choice presentation where applicable and to choose the method by which all persons in the MFBU shall receive their Medi-Cal benefits.

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50175. Denial or Discontinuance Due to Lack of Information, Noncooperation or Loss of Contact.

(a) (1) through (5) unchanged.

(6) The beneficiary fails to choose a health care provider by completing the MC 912 within 30 days of the date of application for assistance.

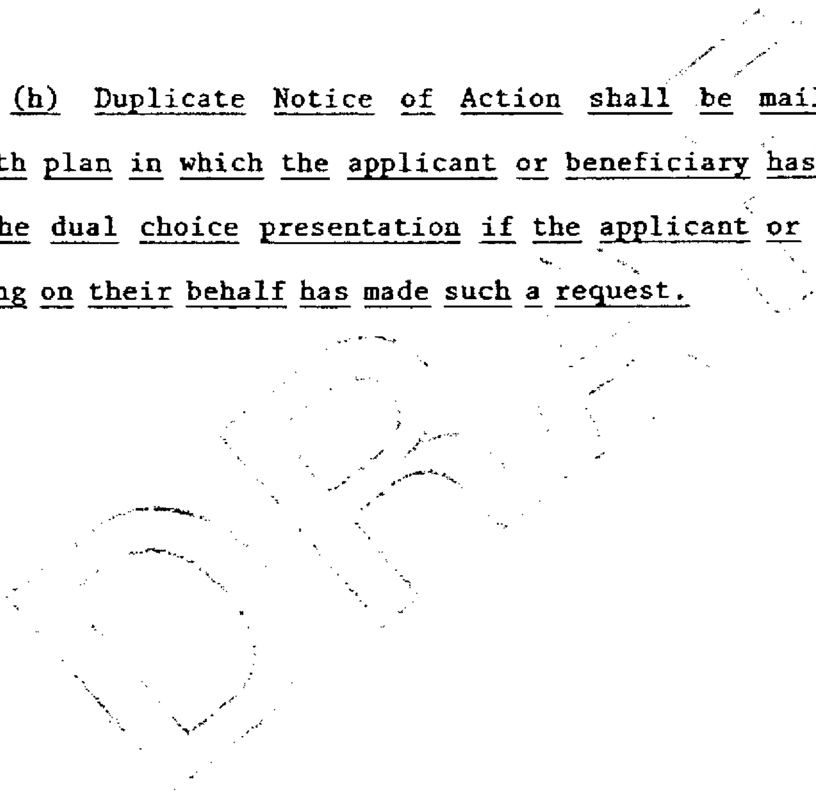
50179. Notice to Applicants and Beneficiaries.

(d) The Notice of Action shall include the following:

Add

(10) A statement to confirm and acknowledge the choice the applicant or beneficiary has made on the MC 912 dual choice form.

(h) Duplicate Notice of Action shall be mailed to the prepaid health plan in which the applicant or beneficiary has enrolled at the time of the dual choice presentation if the applicant or beneficiary or person acting on their behalf has made such a request.



50185. Applicant and Beneficiary General Responsibility.

Add

(a) (8) Attend a county Medi-Cal dual choice presentation, where offered, prior to the eligibility determination.

(9) Choose the method by which all members of the MFBU will receive Medi-Cal benefits and complete the MC 912 choice form.

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50189. Redetermination Frequency and Process.

Add

(b) ______________________________ and a new MC 912 choice form.

(c) The county department shall:

(5) Provide written materials and schedule the beneficiary to attend a verbal dual choice presentation.

DRAFT

Amend to 50227:

(b) Persons receiving a cash grant under any one of the programs specified in (a) shall automatically receive a Medi-Cal card for each month in which they receive the cash grant except for those AFDC persons in (1) who are required to choose the method by which they will receive Medi-Cal benefits under the dual choice program.

53314. Statistical Data.

(a) unchanged.

(b) Each plan shall supply disenrollment data and information as required for the Dual Choice Program.

NEW ARTICLE TITLE 22

DUAL CHOICE INFORMING PROCESS

COUNTY WELFARE DEPARTMENT RESPONSIBILITIES

County welfare departments shall inform all Aid to Families with Dependent Children (AFDC) applicants and annual redetermination clients of their available options to receive Medi-Cal benefits. The county's Dual Choice informing process shall include dissemination of written materials to clients, a verbal group presentation to explain the options, collection of completed choice forms, and shall be completed prior to the final eligibility determination.

1. County staff shall provide each applicant with written materials as approved by the Department.

   a. The written materials shall include the state program brochure; the health plan's or plans' informational brochure, the State Choice Form (MC 912); and, where available, the local medical society brochure.

   b. The written materials shall be distributed prior to the verbal presentation.

   c. The county shall maintain sufficient materials inventory and shall requisition state materials through the Department, shall

requisition plan materials directly from the health plans, and shall requisition local medical society materials directly from the local medical society.

2. Based on the number of offices involved, each county welfare department office shall select one employee who shall fulfill the responsibilities of the Dual Choice Program (the employee shall meet the criteria in Section 50105).

   a. The specially designated Dual Choice county employee shall verbally explain the Dual Choice Program to applicants and clients at a group presentation prior to the time that eligibility is determined or redetermined.

   b. The responsibilities of the Dual Choice worker shall be:

      (1) Conduct the group presentation.

      (2) Explain the Medi-Cal Choice Benefits Form (MC 912) and assist clients in completion of the (MC 912) choice form.

      (3) Provide clients with a completed copy of the MC 912.

      (4) Forward original copy of MC 912 to the health plan to be used as an enrollment document.

(5) Provide a copy of the MC 912 to the case worker for retention in the case file.

(6) Serve as a county liaison for resolution of client/plan enrollment problems.

(7) Maintain program statistics as required by the Department.

(8) Attend periodic program training conducted by the Department.

(9) Attend the monthly monitoring committee meetings.

3. The verbal Dual Choice presentation must comply with the format developed by the Department. The presentation must include all information necessary to enable the client to make a well-informed choice. The following information must be discussed:

   a. Description of the Medi-Cal card option and how clients choosing the card may receive medical care.

   b. Location of existing county hospitals.

   c. If a telephone physician locater/referral service is offered by the local medical society, the telephone number shall be provided.

   d. Costs to client for either option described in (a) and (b).

e. Brief explanation of services offered through the Medi-Cal program. If the plan does not offer the full scope of services, explain which are available through the plan and if a restricted Medi-Cal card will be issued to cover other services.

f. Description, name, and location(s) of the health plan(s) facilities including clinics, hospitals, laboratories, and administrative offices.

g. Statement that health plan enrollment requires sole use of health plan providers.

h. Explanation of process to obtain emergency medical services for plan enrollees.

i. Explanation of health plan grievance and disenrollment procedure.

j. Explanation of process and time required to receive plan membership card. Clarification that plan members do not receive Medi-Cal cards.

k. Statement that the choice is voluntary and will not affect the amount of the cash grant or the eligibility determination.

l. Explanation of whom to contact for future questions regarding the choice. Procedure to be followed if the client wishes to change the choice at a later date.

m. Closing statement soliciting unanswered questions from the group.

4. Dual Choice presentations shall be conducted in a group setting. Dual Choice presentations shall not be routinely presented to recipients individually.

5. When the health plan is county operated, the duties of the Dual Choice worker shall be performed by a state employee or by an independent contractor.

6. The county shall schedule all applicants and renewal beneficiaries to attend the group Dual Choice presentations prior to the final eligibility determination.

   . The county shall ensure that each client receive the Dual Choice information at the time of the initial application and no less frequently than annually, thereafter.

7. The county shall retain the MC 912 choice form in the client's welfare case file to provide documentation of the presentation and of the decision. Upon request from the Department, these files shall be made available for review to monitor compliance.

8. The county shall confirm the recipient's choice by including an acknowledgment statement of the approval Notice of Action.

9. The county shall operate the Dual Choice Program within the annual program fiscal appropriation.

10. The county shall provide representation to the monthly monitoring committee meetings as referenced in Section _____.

11. The county shall inform all affected eligibility staff about the Dual Choice Program and process.

NEW ARTICLE TITLE 22

STATISTICAL REPORTING AND DATA COLLECTION

1. County welfare departments shall report Dual Choice statistical data monthly to the Dual Choice Unit of the Department.

2. The county shall use the form prescribed or approved by the Department.

3. Where there is more than one county office offering Dual Choice, the required statistical information shall be reported by individual office and a consolidated countywide statistical report shall also be prepared.

4. The monthly statistical data shall be separately reported for intake and redetermination cases.

5. The monthly statistical data shall be as follows:

   a. The total number of intake and annual redetermination cases and persons count receiving the Dual Choice information.

   b. The total number and percentage of Medi-Cal card choices and persons count.

   c. The total number and percentage of health plan choices and persons count.

d. The total number and percentage of split choices and persons count.

e. The total number and percentage of no/refused choices and persons count.

6. The information shall be submitted to the Dual Choice Unit no later than five working days after the last day of the month.

NEW ARTICLE TITLE 22

RESPONSIBILITIES OF THE PREPAID HEALTH PLANS

1. Materials.

Prepaid health plans shall provide membership brochures and general informational brochures to be disseminated at the county presentations.

a. The materials must meet the criteria specified in Section 53452.

b. The materials shall be provided at no cost to the Department or to the county.

2. Participation in training of county Dual Choice staff.

The plans shall participate in training county Dual Choice workers at the request of the Department.

. Such training shall include a tour of the plan facilities, an explanation of the available services, and a presentation of the history of the plan.

3. Participation at monthly monitoring committee meetings.

Each plan shall designate a representative who shall attend the monthly monitoring committee meetings as referenced in Section

a. The plan representative shall provide data to the committee on the number of Dual Choice-generated members who have disenrolled.

. The disenrollment data shall include the client Medi-Cal name and numbers, the total number of persons, date of enrollment, date of request for disenrollment, effective date of disenrollment, and the reason given for disenrollment.

b. The plan representative shall identify problems and/or changes within the plan pertaining to Dual Choice and present these to the committee for discussion.

RESPONSIBILITIES OF THE APPLICANT/BENEFICIARY

1. Each applicant and renewal beneficiary shall attend a scheduled county Dual Choice presentation prior to the final eligibility determination.

. Each Medi-Cal Family Budget Unit shall have 30 days to choose between the Medi-Cal card and the plan.

2. Each applicant and renewal beneficiary shall complete the MC 912, Medi-Cal Benefit Choice Form, as a part of the applicant and/or annual renewal process.

. Each applicant shall indicate the choice for each member of the Medi-Cal Family Budget Unit.

3. Each applicant/beneficiary who has chosen to enroll in a health plan shall notify the health plan of any changes in the complete Medi-Cal number, including a change to the aid code number.

4. The applicants/beneficiaries who are enrolled in a prepaid health plan must contact the health plan to disenroll.

MONTHLY MONITORING COMMITTEE MEETINGS

1. For the purposes of monitoring and evaluating the Dual Choice Program and mutually resolving problems, a monitoring committee shall be formed and shall include designated representatives from:

   a. The Department.

   b. The county.

   c. The health plan(s).

2. The monitoring committee shall meet no less frequently than monthly.

3. The responsibilities of the monitoring committee shall be as follows:

   a. Department Representative

(1) Review statistics from county and plan to determine choice rate, actual enrollment rate, and grievance disenrollment rate.

(2) Make recommendations for improvement in all areas of the Dual Choice.

(3) Liaison to the Department's management.

(4) Chair, schedule, prepare agenda and minutes; and retain primary responsibility for the monitoring committee.

b. County Representative

(1) Collect statistics from each county office. The statistics shall include the information required in Section _____. Present these statistics to the committee at each meeting.

(2) Liaison to the county administration.

(3) Identify problems within the county office pertaining to Dual Choice to present to the committee for mutual resolution.

c. Plan Representative

(1) Provide statistics as required in Section _____ to the committee.

(2) Provide information to the evaluation committee pertaining to reasons for such actions.

(3) Liaison to the plan administrators.

(4) Identify problems/changes within the plan pertaining to Dual Choice to present to the committee for mutual resolution.

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 repealed.

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

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

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

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

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

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

In areas where there is no prepaid health plan which has ontracted with the department to provide services to Medi-Cal eneficiaries, no explicit choice need be made, and the beneficiary r 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 program to implement the provisions of Section 14016.5. The rogram shall include, but not be limited to, the following omponents:

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

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

(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.

O