

AMENDED IN SENATE JUNE 13, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 100

Introduced by Committee on Budget (Blumenfield (Chair), Bloom, Bonilla, Campos, Chesbro, Daly, Dickinson, Gordon, Jones-Sawyer, Mitchell, Mullin, Muratsuchi, Nazarian, Rendon, Skinner, Stone, and Ting)

January 10, 2013

An act relating to the Budget Act of 2013. An act to amend Section 6253.2 of the Government Code, to amend Sections 10101.1, 12300.7, 12306, 12306.1, 12306.15, 14182.16, 14182.17, 14186, 14186.1, 14186.2, 14186.3, 14186.36, and 14186.4 of, to amend and add Sections 14132.275, 14183.6 and 14301.1, of, and to add Sections 14132.277, 14182.18, and 14186.11 to, the Welfare and Institutions Code, to repeal Section 10 of Chapter 33 of the Statutes of 2012, and to repeal Sections 15, 16, and 17 of Chapter 45 of the Statutes of 2012, relating to Medi-Cal, and making an appropriation therefor, to take effect immediately, bill related to the budget.

LEGISLATIVE COUNSEL'S DIGEST

AB 100, as amended, Committee on Budget. ~~Budget Act of 2013.~~ *Medi-Cal: managed care: long-term services and supports: in-home supportive services.*

(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires the department to seek federal approval to establish a demonstration project as

described in law pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination thereof. Existing law provides that if the department has not received by February 1, 2013, federal approval, or notification indicating pending approval, of a mutual ratesetting process, shared federal savings, and a 6-month enrollment period in the demonstration project, effective March 1, 2013, Chapter 45 of the Statutes of 2012, and specified provisions of Chapter 33 of the Statutes of 2012, are inoperative, as provided. Chapter 33 of the Statutes of 2012, among other things, requires that Medi-Cal beneficiaries who have dual eligibility in the Medi-Cal and Medicare programs be assigned as mandatory enrollees into managed care plans in counties participating in the demonstration project, and requires that no sooner than March 1, 2013, all Medi-Cal long-term services and supports, which includes Multipurpose Senior Services Program (MSSP) services, be covered under managed care plan contracts and only available through managed care plans to beneficiaries residing in counties participating in the demonstration project. Chapter 45 of the Statutes of 2012, among other things, establishes the California In-Home Supportive Services Authority (Statewide Authority), and provides that the In-Home Supportive Services Program is a Medi-Cal benefit available through managed care health care plans in specified counties, as specified. Existing law provides that no sooner than March 1, 2103, the Statewide Authority shall assume specified responsibilities in a county or city and county upon notification by the Director of Health Care Services that the enrollment of eligible Medi-Cal beneficiaries described in specified provisions of law has been completed in that county or city and county.

This bill would instead require enrollment of eligible Medi-Cal beneficiaries into managed care pursuant to the demonstration project or other specified provisions, including managed care for long-term services and supports, as one of the conditions that would be required to be completed before the Statewide Authority assumes the specified responsibilities. The bill would modify the provisions governing when MSSP becomes a Medi-Cal benefit only through managed care health plans, as prescribed. The bill would delete the provision authorizing the Director of Health Care Services to forgo the provision of long-term services and supports only through managed care, in its entirety or partially, if and to the extent the director determines that the quality of care for managed care beneficiaries, efficiency, or cost-effectiveness of the program would be jeopardized. The bill would require the State

Department of Health Care Services to convene quarterly meetings with stakeholders to make recommendations regarding the Coordinated Care Initiative, as specified. The bill would require that in Coordinated Care Initiative Counties for managed care health plans providing long-term services and supports, the department shall include in its contract with those plans risk corridors to provide protections against either significant overpayment or significant underpayments. The bill would also repeal the provisions conditioning the operation of Chapter 45 of the Statutes of 2012 and specified provisions of Chapter 33 of the Statutes of 2012 on receipt of federal approval or notification of pending approval by February 1, 2013. The bill would instead condition implementation of the Coordinated Care Initiative, as defined, on whether the Director of Finance estimates that the Coordinated Care Initiative will generate net General Fund savings, as specified. The bill would also make other related technical, nonsubstantive changes.

(2) The bill would appropriate the amount of \$500,000 from the General Fund to the State Department of Health Care Services for the Coordinated Care Initiative for purposes of notifying dual eligible beneficiaries and providers regarding the provisions of this act, and would provide that those funds be available for encumbrance and expenditure until June 30, 2014.

(3) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2013.~~

Vote: majority. Appropriation: ~~no~~ yes. Fiscal committee: ~~no~~ yes. State-mandated local program: no.

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

1 SECTION 1. Section 6253.2 of the Government Code, as
 2 amended by Section 2 of Chapter 439 of the Statutes of 2012, is
 3 amended to read:
 4 6253.2. (a) Notwithstanding any other provision of this chapter
 5 to the contrary, information regarding persons paid by the state to
 6 provide in-home supportive services pursuant to Article 7
 7 (commencing with Section 12300) of Chapter 3 of Part 3 of
 8 Division 9 of the Welfare and Institutions Code, or services
 9 provided pursuant to Section 14132.95, 14132.952, or 14132.956
 10 of the Welfare and Institutions Code, ~~shall~~ is not be subject to

1 public disclosure pursuant to this chapter, except as provided in
 2 subdivision (b).

3 (b) Copies of names, addresses, and telephone numbers of
 4 persons described in subdivision (a) shall be made available, upon
 5 request, to an exclusive bargaining agent and to any labor
 6 organization seeking representation rights pursuant to Section
 7 12301.6 or 12302.25 of the Welfare and Institutions Code or the
 8 In-Home Supportive Services Employer-Employee Relations Act
 9 (Title 23 (commencing with Section 110000)). This information
 10 shall not be used by the receiving entity for any purpose other than
 11 the employee organizing, representation, and assistance activities
 12 of the labor organization.

13 (c) This section ~~shall apply~~ *applies* solely to individuals who
 14 provide services under the In-Home Supportive Services Program
 15 (Article 7 (commencing with Section 12300) of Chapter 3 of Part
 16 3 of Division 9 of the Welfare and Institutions Code), the Personal
 17 Care Services Program pursuant to Section 14132.95 of the Welfare
 18 and Institutions Code, the In-Home Supportive Services Plus
 19 Option pursuant to Section 14132.952 of the Welfare and
 20 Institutions Code, or the Community First Choice Option pursuant
 21 to Section 14132.956 of the Welfare and Institutions Code.

22 (d) Nothing in this section is intended to alter or shall be
 23 interpreted to alter the rights of parties under the In-Home
 24 Supportive Services Employer-Employee Relations Act (Title 23
 25 (commencing with Section 110000)) or any other labor relations
 26 law.

27 ~~(e) This section shall become inoperative only if Chapter 45 of~~
 28 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
 29 ~~of that chapter.~~

30 *(e) This section shall be inoperative if the Coordinated Care*
 31 *Initiative becomes inoperative pursuant to Section 34 of the act*
 32 *that added this subdivision.*

33 *SEC. 2. Section 6253.2 of the Government Code, as amended*
 34 *by Section 1 of Chapter 439 of the Statutes of 2012, is amended*
 35 *to read:*

36 6253.2. (a) Notwithstanding any other provision of this chapter
 37 to the contrary, information regarding persons paid by the state to
 38 provide in-home supportive services pursuant to Article 7
 39 (commencing with Section 12300) of Chapter 3 of Part 3 of
 40 Division 9 of the Welfare and Institutions Code or personal care

1 services pursuant to Section 14132.95 of the Welfare and
2 Institutions Code, ~~shall~~ *is not be* subject to public disclosure
3 pursuant to this chapter, except as provided in subdivision (b).

4 (b) Copies of names, addresses, and telephone numbers of
5 persons described in subdivision (a) shall be made available, upon
6 request, to an exclusive bargaining agent and to any labor
7 organization seeking representation rights pursuant to subdivision
8 (c) of Section 12301.6 or Section 12302.25 of the Welfare and
9 Institutions Code or Chapter 10 (commencing with Section 3500)
10 of Division 4 of Title 1. This information shall not be used by the
11 receiving entity for any purpose other than the employee
12 organizing, representation, and assistance activities of the labor
13 organization.

14 (c) This section ~~shall apply~~ *applies* solely to individuals who
15 provide services under the In-Home Supportive Services Program
16 (Article 7 (commencing with Section 12300) of Chapter 3 of Part
17 3 of Division 9 of the Welfare and Institutions Code) or the
18 Personal Care Services Program pursuant to Section 14132.95 of
19 the Welfare and Institutions Code.

20 (d) Nothing in this section is intended to alter or shall be
21 interpreted to alter the rights of parties under the
22 Meyers-Milias-Brown Act (Chapter 10 (commencing with Section
23 3500) of Division 4) or any other labor relations law.

24 ~~(e) This section shall become operative only if Chapter 45 of~~
25 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
26 ~~of that chapter.~~

27 *(e) This section shall be operative only if Section 1 of the act*
28 *that added this subdivision becomes inoperative pursuant to*
29 *subdivision (e) of that Section 1.*

30 *SEC. 3. [Reserved]*

31 *SEC. 4. [Reserved]*

32 *SEC. 5. Section 10101.1 of the Welfare and Institutions Code,*
33 *as amended by Section 23 of Chapter 439 of the Statutes of 2012,*
34 *is amended to read:*

35 10101.1. (a) For the 1991–92 fiscal year and each fiscal year
36 thereafter, the state’s share of the costs of the county services block
37 grant and the in-home supportive services administration
38 requirements shall be 70 percent of the actual nonfederal
39 expenditures or the amount appropriated by the Legislature for
40 that purpose, whichever is less.

1 (b) Federal funds received under Title 20 of the federal Social
 2 Security Act (42 U.S.C. Sec. 1397 et seq.) and appropriated by the
 3 Legislature for the county services block grant and the in-home
 4 supportive services administration shall be considered part of the
 5 state share of cost and not part of the federal expenditures for this
 6 purpose.

7 (c) For the period during which Section 12306.15 is operative,
 8 each county’s share of the nonfederal costs of the county services
 9 block grant and the in-home supportive services administration
 10 requirements as specified in subdivision (a) shall remain, but the
 11 County IHSS Maintenance of Effort pursuant to Section 12306.15
 12 shall be in lieu of that share.

13 ~~(d) This section shall become inoperative only if Chapter 45 of~~
 14 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
 15 ~~of that chapter.~~

16 *(d) This section shall be inoperative if the Coordinated Care*
 17 *Initiative becomes inoperative pursuant to Section 34 of the act*
 18 *that added this subdivision.*

19 *SEC. 6. Section 10101.1 of the Welfare and Institutions Code,*
 20 *as amended by Section 22 of Chapter 439 of the Statutes of 2012,*
 21 *is amended to read:*

22 10101.1. (a) For the 1991–92 fiscal year and each fiscal year
 23 thereafter, the state’s share of the costs of the county services block
 24 grant and the in-home supportive services administration
 25 requirements shall be 70 percent of the actual nonfederal
 26 expenditures or the amount appropriated by the Legislature for
 27 that purpose, whichever is less.

28 (b) Federal funds received under Title 20 of the federal Social
 29 Security Act (42 U.S.C. Sec. 1397 et seq.) and appropriated by the
 30 Legislature for the county services block grant and the in-home
 31 supportive services administration shall be considered part of the
 32 state share of cost and not part of the federal expenditures for this
 33 purpose.

34 ~~(e) This section shall become operative only if Chapter 45 of~~
 35 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
 36 ~~of that chapter.~~

37 *(c) This section shall be operative only if Section 5 of the act*
 38 *that added this subdivision becomes inoperative pursuant to*
 39 *subdivision (d) of that Section 5.*

1 *SEC. 7. Section 12300.7 of the Welfare and Institutions Code*
2 *is amended to read:*

3 12300.7. (a) No sooner than March 1, 2013, the California
4 In-Home Supportive Services Authority shall assume the
5 responsibilities set forth in Title 23 (commencing with Section
6 110000) of the Government Code in a county or city and county
7 upon notification by the Director of Health Care Services that the
8 enrollment of eligible Medi-Cal beneficiaries described in ~~Sections~~
9 ~~14132.275, Section 14132.275 or 14182.16, and 14182.17 or~~
10 Article 5.7 (commencing with Section 14186) of Chapter 7 has
11 been completed in that county or city and county.

12 (b) A county or city and county, subject to subdivision (a) and
13 upon notification from the Director of Health Care Services, shall
14 do one or both of the following:

15 (1) Have the entity that performed functions set forth in the
16 county ordinance or contract in effect at the time of the notification
17 pursuant to subdivision (a) and established pursuant to Section
18 12301.6 continue to perform those functions, excluding subdivision
19 (c) of that section.

20 (2) Assume the functions performed by the entity, at the time
21 of the notification pursuant to subdivision (a), pursuant to Section
22 12301.6, excluding subdivision (c) of that section.

23 (c) If a county or city and county assumes the functions
24 described in paragraph (2) of subdivision (b), it may establish or
25 contract with an entity for the performance of any or all of the
26 functions assumed.

27 *SEC. 8. Section 12306 of the Welfare and Institutions Code,*
28 *as amended by Section 37 of Chapter 439 of the Statutes of 2012,*
29 *is amended to read:*

30 12306. (a) The state and counties shall share the annual cost
31 of providing services under this article as specified in this section.

32 (b) Except as provided in subdivisions (c) and (d), the state shall
33 pay to each county, from the General Fund and any federal funds
34 received under Title XX of the federal Social Security Act available
35 for that purpose, 65 percent of the cost of providing services under
36 this article, and each county shall pay 35 percent of the cost of
37 providing those services.

38 (c) For services eligible for federal funding pursuant to Title
39 XIX of the federal Social Security Act under the Medi-Cal program
40 and, except as provided in subdivisions (b) and (d) the state shall

1 pay to each county, from the General Fund and any funds available
 2 for that purpose 65 percent of the nonfederal cost of providing
 3 services under this article, and each county shall pay 35 percent
 4 of the nonfederal cost of providing those services.

5 (d) (1) For the period of July 1, 1992, to June 30, 1994,
 6 inclusive, the state’s share of the cost of providing services under
 7 this article shall be limited to the amount appropriated for that
 8 purpose in the annual Budget Act.

9 (2) The department shall restore the funding reductions required
 10 by subdivision (c) of Section 12301, fully or in part, as soon as
 11 administratively practicable, if the amount appropriated from the
 12 General Fund for the 1992–93 fiscal year under this article is
 13 projected to exceed the sum of the General Fund expenditures
 14 under Section 14132.95 and the actual General Fund expenditures
 15 under this article for the 1992–93 fiscal year. The entire amount
 16 of the excess shall be applied to the restoration. Services shall not
 17 be restored under this paragraph until the Department of Finance
 18 has determined that the restoration of services would result in no
 19 additional costs to the state or to the counties relative to the
 20 combined state appropriation and county matching funds for
 21 in-home supportive services under this article in the 1992–93 fiscal
 22 year.

23 (e) For the period during which Section 12306.15 is operative,
 24 each county’s share of the costs of providing services pursuant to
 25 this article specified in subdivisions (b) and (c) shall remain, but
 26 the County IHSS Maintenance of Effort pursuant to Section
 27 12306.15 shall be in lieu of that share.

28 ~~(f) This section shall become inoperative only if Chapter 45 of~~
 29 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
 30 ~~of that chapter.~~

31 *(f) This section shall be inoperative if the Coordinated Care*
 32 *Initiative becomes inoperative pursuant to Section 34 of the act*
 33 *that added this subdivision.*

34 *SEC. 9. Section 12306 of the Welfare and Institutions Code,*
 35 *as amended by Section 36 of Chapter 439 of the Statutes of 2012,*
 36 *is amended to read:*

37 12306. (a) The state and counties shall share the annual cost
 38 of providing services under this article as specified in this section.

39 (b) Except as provided in subdivisions (c) and (d), the state shall
 40 pay to each county, from the General Fund and any federal funds

1 received under Title XX of the federal Social Security Act available
2 for that purpose, 65 percent of the cost of providing services under
3 this article, and each county shall pay 35 percent of the cost of
4 providing those services.

5 (c) For services eligible for federal funding pursuant to Title
6 XIX of the federal Social Security Act under the Medi-Cal program
7 and, except as provided in subdivisions (b) and (d) the state shall
8 pay to each county, from the General Fund and any funds available
9 for that purpose 65 percent of the nonfederal cost of providing
10 services under this article, and each county shall pay 35 percent
11 of the nonfederal cost of providing those services.

12 (d) (1) For the period of July 1, 1992, to June 30, 1994,
13 inclusive, the state’s share of the cost of providing services under
14 this article shall be limited to the amount appropriated for that
15 purpose in the annual Budget Act.

16 (2) The department shall restore the funding reductions required
17 by subdivision (c) of Section 12301, fully or in part, as soon as
18 administratively practicable, if the amount appropriated from the
19 General Fund for the 1992–93 fiscal year under this article is
20 projected to exceed the sum of the General Fund expenditures
21 under Section 14132.95 and the actual General Fund expenditures
22 under this article for the 1992–93 fiscal year. The entire amount
23 of the excess shall be applied to the restoration. Services shall not
24 be restored under this paragraph until the Department of Finance
25 has determined that the restoration of services would result in no
26 additional costs to the state or to the counties relative to the
27 combined state appropriation and county matching funds for
28 in-home supportive services under this article in the 1992–93 fiscal
29 year.

30 ~~(e) This section shall become operative only if Chapter 45 of~~
31 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
32 ~~of that chapter.~~

33 *(e) This section shall be operative only if Section 8 of the act*
34 *that added this subdivision becomes inoperative pursuant to*
35 *subdivision (f) of that Section 8.*

36 *SEC. 10. Section 12306.1 of the Welfare and Institutions Code,*
37 *as amended by Section 7 of Chapter 4 of the Statutes of 2013, is*
38 *amended to read:*

39 12306.1. (a) When any increase in provider wages or benefits
40 is negotiated or agreed to by a public authority or nonprofit

1 consortium under Section 12301.6, then the county shall use
2 county-only funds to fund both the county share and the state share,
3 including employment taxes, of any increase in the cost of the
4 program, unless otherwise provided for in the annual Budget Act
5 or appropriated by statute. No increase in wages or benefits
6 negotiated or agreed to pursuant to this section shall take effect
7 unless and until, prior to its implementation, the department has
8 obtained the approval of the State Department of Health Care
9 Services for the increase pursuant to a determination that it is
10 consistent with federal law and to ensure federal financial
11 participation for the services under Title XIX of the federal Social
12 Security Act, and unless and until all of the following conditions
13 have been met:

14 (1) Each county has provided the department with
15 documentation of the approval of the county board of supervisors
16 of the proposed public authority or nonprofit consortium rate,
17 including wages and related expenditures. The documentation shall
18 be received by the department before the department and the State
19 Department of Health Care Services may approve the increase.

20 (2) Each county has met department guidelines and regulatory
21 requirements as a condition of receiving state participation in the
22 rate.

23 (b) Any rate approved pursuant to subdivision (a) shall take
24 effect commencing on the first day of the month subsequent to the
25 month in which final approval is received from the department.
26 The department may grant approval on a conditional basis, subject
27 to the availability of funding.

28 (c) The state shall pay 65 percent, and each county shall pay 35
29 percent, of the nonfederal share of wage and benefit increases
30 negotiated by a public authority or nonprofit consortium pursuant
31 to Section 12301.6 and associated employment taxes, only in
32 accordance with subdivisions (d) to (f), inclusive.

33 (d) (1) The state shall participate as provided in subdivision (c)
34 in wages up to seven dollars and fifty cents (\$7.50) per hour and
35 individual health benefits up to sixty cents (\$0.60) per hour for all
36 public authority or nonprofit consortium providers. This paragraph
37 shall be operative for the 2000–01 fiscal year and each year
38 thereafter unless otherwise provided in paragraphs (2), (3), (4),
39 and (5), and without regard to when the wage and benefit increase
40 becomes effective.

1 (2) The state shall participate as provided in subdivision (c) in
2 a total of wages and individual health benefits up to nine dollars
3 and ten cents (\$9.10) per hour, if wages have reached at least seven
4 dollars and fifty cents (\$7.50) per hour. Counties shall determine,
5 pursuant to the collective bargaining process provided for in
6 subdivision (c) of Section 12301.6, what portion of the nine dollars
7 and ten cents (\$9.10) per hour shall be used to fund wage increases
8 above seven dollars and fifty cents (\$7.50) per hour or individual
9 health benefit increases, or both. This paragraph shall be operative
10 for the 2001–02 fiscal year and each fiscal year thereafter, unless
11 otherwise provided in paragraphs (3), (4), and (5).

12 (3) The state shall participate as provided in subdivision (c) in
13 a total of wages and individual health benefits up to ten dollars
14 and ten cents (\$10.10) per hour, if wages have reached at least
15 seven dollars and fifty cents (\$7.50) per hour. Counties shall
16 determine, pursuant to the collective bargaining process provided
17 for in subdivision (c) of Section 12301.6, what portion of the ten
18 dollars and ten cents (\$10.10) per hour shall be used to fund wage
19 increases above seven dollars and fifty cents (\$7.50) per hour or
20 individual health benefit increases, or both. This paragraph shall
21 be operative commencing with the next state fiscal year for which
22 the May Revision forecast of General Fund revenue, excluding
23 transfers, exceeds by at least 5 percent, the most current estimate
24 of revenue, excluding transfers, for the year in which paragraph
25 (2) became operative.

26 (4) The state shall participate as provided in subdivision (c) in
27 a total of wages and individual health benefits up to eleven dollars
28 and ten cents (\$11.10) per hour, if wages have reached at least
29 seven dollars and fifty cents (\$7.50) per hour. Counties shall
30 determine, pursuant to the collective bargaining process provided
31 for in subdivision (c) of Section 12301.6, what portion of the eleven
32 dollars and ten cents (\$11.10) per hour shall be used to fund wage
33 increases or individual health benefits, or both. This paragraph
34 shall be operative commencing with the next state fiscal year for
35 which the May Revision forecast of General Fund revenue,
36 excluding transfers, exceeds by at least 5 percent, the most current
37 estimate of revenues, excluding transfers, for the year in which
38 paragraph (3) became operative.

39 (5) The state shall participate as provided in subdivision (c) in
40 a total cost of wages and individual health benefits up to twelve

1 dollars and ten cents (\$12.10) per hour, if wages have reached at
2 least seven dollars and fifty cents (\$7.50) per hour. Counties shall
3 determine, pursuant to the collective bargaining process provided
4 for in subdivision (c) of Section 12301.6, what portion of the
5 twelve dollars and ten cents (\$12.10) per hour shall be used to fund
6 wage increases above seven dollars and fifty cents (\$7.50) per hour
7 or individual health benefit increases, or both. This paragraph shall
8 be operative commencing with the next state fiscal year for which
9 the May Revision forecast of General Fund revenue, excluding
10 transfers, exceeds by at least 5 percent, the most current estimate
11 of revenues, excluding transfers, for the year in which paragraph
12 (4) became operative.

13 (e) (1) On or before May 14 immediately prior to the fiscal
14 year for which state participation is provided under paragraphs (2)
15 to (5), inclusive, of subdivision (d), the Director of Finance shall
16 certify to the Governor, the appropriate committees of the
17 Legislature, and the department that the condition for each
18 subdivision to become operative has been met.

19 (2) For purposes of certifications under paragraph (1), the
20 General Fund revenue forecast, excluding transfers, that is used
21 for the relevant fiscal year shall be calculated in a manner that is
22 consistent with the definition of General Fund revenues, excluding
23 transfers, that was used by the Department of Finance in the
24 2000–01 Governor’s Budget revenue forecast as reflected on
25 Schedule 8 of the Governor’s Budget.

26 (f) Any increase in overall state participation in wage and benefit
27 increases under paragraphs (2) to (5), inclusive, of subdivision (d),
28 shall be limited to a wage and benefit increase of one dollar (\$1)
29 per hour with respect to any fiscal year. With respect to actual
30 changes in specific wages and health benefits negotiated through
31 the collective bargaining process, the state shall participate in the
32 costs, as approved in subdivision (c), up to the maximum levels
33 as provided under paragraphs (2) to (5), inclusive, of subdivision
34 (d).

35 (g) For the period during which Section 12306.15 is operative,
36 each county’s share of the costs of negotiated wage and benefit
37 increases specified in subdivision (c) shall remain, but the County
38 IHSS Maintenance of Effort pursuant to Section 12306.15 shall
39 be in lieu of that share.

1 ~~(h) This section shall become inoperative only if Chapter 45 of~~
2 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
3 ~~of that chapter.~~

4 *(h) This section shall be inoperative if the Coordinated Care*
5 *Initiative becomes inoperative pursuant to Section 34 of the act*
6 *that added this subdivision.*

7 *SEC. 11. Section 12306.1 of the Welfare and Institutions Code,*
8 *as amended by Section 8 of Chapter 4 of the Statutes of 2013, is*
9 *amended to read:*

10 12306.1. (a) When any increase in provider wages or benefits
11 is negotiated or agreed to by a public authority or nonprofit
12 consortium under Section 12301.6, then the county shall use
13 county-only funds to fund both the county share and the state share,
14 including employment taxes, of any increase in the cost of the
15 program, unless otherwise provided for in the annual Budget Act
16 or appropriated by statute. No increase in wages or benefits
17 negotiated or agreed to pursuant to this section shall take effect
18 unless and until, prior to its implementation, the department has
19 obtained the approval of the State Department of Health Care
20 Services for the increase pursuant to a determination that it is
21 consistent with federal law and to ensure federal financial
22 participation for the services under Title XIX of the federal Social
23 Security Act, and unless and until all of the following conditions
24 have been met:

25 (1) Each county has provided the department with
26 documentation of the approval of the county board of supervisors
27 of the proposed public authority or nonprofit consortium rate,
28 including wages and related expenditures. The documentation shall
29 be received by the department before the department and the State
30 Department of Health Care Services may approve the increase.

31 (2) Each county has met department guidelines and regulatory
32 requirements as a condition of receiving state participation in the
33 rate.

34 (b) Any rate approved pursuant to subdivision (a) shall take
35 effect commencing on the first day of the month subsequent to the
36 month in which final approval is received from the department.
37 The department may grant approval on a conditional basis, subject
38 to the availability of funding.

39 (c) The state shall pay 65 percent, and each county shall pay 35
40 percent, of the nonfederal share of wage and benefit increases

1 negotiated by a public authority or nonprofit consortium pursuant
2 to Section 12301.6 and associated employment taxes, only in
3 accordance with subdivisions (d) to (f), inclusive.

4 (d) (1) The state shall participate as provided in subdivision (c)
5 in wages up to seven dollars and fifty cents (\$7.50) per hour and
6 individual health benefits up to sixty cents (\$0.60) per hour for all
7 public authority or nonprofit consortium providers. This paragraph
8 shall be operative for the 2000–01 fiscal year and each year
9 thereafter unless otherwise provided in paragraphs (2), (3), (4),
10 and (5), and without regard to when the wage and benefit increase
11 becomes effective.

12 (2) The state shall participate as provided in subdivision (c) in
13 a total of wages and individual health benefits up to nine dollars
14 and ten cents (\$9.10) per hour, if wages have reached at least seven
15 dollars and fifty cents (\$7.50) per hour. Counties shall determine,
16 pursuant to the collective bargaining process provided for in
17 subdivision (c) of Section 12301.6, what portion of the nine dollars
18 and ten cents (\$9.10) per hour shall be used to fund wage increases
19 above seven dollars and fifty cents (\$7.50) per hour or individual
20 health benefit increases, or both. This paragraph shall be operative
21 for the 2001–02 fiscal year and each fiscal year thereafter, unless
22 otherwise provided in paragraphs (3), (4), and (5).

23 (3) The state shall participate as provided in subdivision (c) in
24 a total of wages and individual health benefits up to ten dollars
25 and ten cents (\$10.10) per hour, if wages have reached at least
26 seven dollars and fifty cents (\$7.50) per hour. Counties shall
27 determine, pursuant to the collective bargaining process provided
28 for in subdivision (c) of Section 12301.6, what portion of the ten
29 dollars and ten cents (\$10.10) per hour shall be used to fund wage
30 increases above seven dollars and fifty cents (\$7.50) per hour or
31 individual health benefit increases, or both. This paragraph shall
32 be operative commencing with the next state fiscal year for which
33 the May Revision forecast of General Fund revenue, excluding
34 transfers, exceeds by at least 5 percent, the most current estimate
35 of revenue, excluding transfers, for the year in which paragraph
36 (2) became operative.

37 (4) The state shall participate as provided in subdivision (c) in
38 a total of wages and individual health benefits up to eleven dollars
39 and ten cents (\$11.10) per hour, if wages have reached at least
40 seven dollars and fifty cents (\$7.50) per hour. Counties shall

1 determine, pursuant to the collective bargaining process provided
2 for in subdivision (c) of Section 12301.6, what portion of the eleven
3 dollars and ten cents (\$11.10) per hour shall be used to fund wage
4 increases or individual health benefits, or both. This paragraph
5 shall be operative commencing with the next state fiscal year for
6 which the May Revision forecast of General Fund revenue,
7 excluding transfers, exceeds by at least 5 percent, the most current
8 estimate of revenues, excluding transfers, for the year in which
9 paragraph (3) became operative.

10 (5) The state shall participate as provided in subdivision (c) in
11 a total cost of wages and individual health benefits up to twelve
12 dollars and ten cents (\$12.10) per hour, if wages have reached at
13 least seven dollars and fifty cents (\$7.50) per hour. Counties shall
14 determine, pursuant to the collective bargaining process provided
15 for in subdivision (c) of Section 12301.6, what portion of the
16 twelve dollars and ten cents (\$12.10) per hour shall be used to fund
17 wage increases above seven dollars and fifty cents (\$7.50) per hour
18 or individual health benefit increases, or both. This paragraph shall
19 be operative commencing with the next state fiscal year for which
20 the May Revision forecast of General Fund revenue, excluding
21 transfers, exceeds by at least 5 percent, the most current estimate
22 of revenues, excluding transfers, for the year in which paragraph
23 (4) became operative.

24 (e) (1) On or before May 14 immediately prior to the fiscal
25 year for which state participation is provided under paragraphs (2)
26 to (5), inclusive, of subdivision (d), the Director of Finance shall
27 certify to the Governor, the appropriate committees of the
28 Legislature, and the department that the condition for each
29 subdivision to become operative has been met.

30 (2) For purposes of certifications under paragraph (1), the
31 General Fund revenue forecast, excluding transfers, that is used
32 for the relevant fiscal year shall be calculated in a manner that is
33 consistent with the definition of General Fund revenues, excluding
34 transfers, that was used by the Department of Finance in the
35 2000–01 Governor’s Budget revenue forecast as reflected on
36 Schedule 8 of the Governor’s Budget.

37 (f) Any increase in overall state participation in wage and benefit
38 increases under paragraphs (2) to (5), inclusive, of subdivision (d),
39 shall be limited to a wage and benefit increase of one dollar (\$1)
40 per hour with respect to any fiscal year. With respect to actual

1 changes in specific wages and health benefits negotiated through
 2 the collective bargaining process, the state shall participate in the
 3 costs, as approved in subdivision (c), up to the maximum levels
 4 as provided under paragraphs (2) to (5), inclusive, of subdivision
 5 (d).

6 ~~(g) This section shall become operative only if Chapter 45 of~~
 7 ~~the Statutes of 2012 is deemed inoperative pursuant to Section 15~~
 8 ~~of that chapter.~~

9 *(g) This section shall be operative only if Section 10 of the act*
 10 *that added this subdivision becomes inoperative pursuant to*
 11 *subdivision (h) of that Section 10.*

12 *SEC. 12. Section 12306.15 of the Welfare and Institutions Code*
 13 *is amended to read:*

14 12306.15. (a) Commencing July 1, 2012, all counties shall
 15 have a County IHSS Maintenance of Effort (MOE). In lieu of
 16 paying the nonfederal share of IHSS costs as specified in Sections
 17 10101.1, 12306, and 12306.1, counties shall pay the County IHSS
 18 MOE.

19 (b) (1) The County IHSS MOE base year shall be the 2011–12
 20 state fiscal year. The County IHSS MOE base shall be defined as
 21 the amount actually expended by each county on IHSS services
 22 and administration in the County IHSS MOE base year, as reported
 23 by each county to the department, except that for administration,
 24 the County IHSS MOE base shall include no more or no less than
 25 the full match for the county’s allocation from the state.

26 (2) Administration expenditures shall include both county
 27 administration and public authority administration. The County
 28 IHSS MOE base shall be unique to each individual county.

29 (3) For a county that made 14 months of health benefit payments
 30 for IHSS providers in the 2011–12 fiscal year, the Department of
 31 Finance shall adjust that county’s County IHSS MOE base
 32 calculation.

33 (4) The County IHSS MOE base for each county shall be no
 34 less than each county’s 2011–12 expenditures for the Personal
 35 Care Services Program and IHSS used in the caseload growth
 36 calculation pursuant to Section 17605.

37 (c) (1) On July 1, 2014, the County IHSS MOE base shall be
 38 adjusted by an inflation factor of 3.5 percent.

1 (2) Beginning on July 1, 2015, and annually thereafter, the
2 County IHSS MOE from the previous year shall be adjusted by
3 an inflation factor of 3.5 percent.

4 (3) (A) Notwithstanding paragraphs (1) and (2), in fiscal years
5 when the combined total of 1991 realignment revenues received
6 pursuant to Sections 11001.5, 6051.2, and 6201.2 of the Revenue
7 and Taxation Code, for the prior fiscal year is less than the
8 combined total received for the next prior fiscal year, the inflation
9 factor shall be zero.

10 (B) The Department of Finance shall provide notification to the
11 appropriate legislative fiscal committees and the California State
12 Association of Counties by May 14 of each year whether the
13 inflation factor will apply for the following fiscal year, based on
14 the calculation in subparagraph (A).

15 (d) In addition to the adjustment in subdivision (c), the County
16 IHSS MOE shall be adjusted for the annualized cost of increases
17 in provider wages or health benefits that are locally negotiated,
18 mediated, or imposed before the Statewide Authority assumes the
19 responsibilities set forth in Section 110011 of the Government
20 Code for a given county as provided in Section 12300.7.

21 (1) (A) If the department approves the rates and other economic
22 terms for a locally negotiated, mediated, or imposed increase in
23 the provider wages, health benefits, or other economic terms
24 pursuant to Section 12306.1 and paragraph (3), the state shall pay
25 65 percent, and the affected county shall pay 35 percent, of the
26 nonfederal share of the cost increase in accordance with
27 subparagraph (B).

28 (B) With respect to any increase in provider wages or health
29 benefits approved after July 1, 2012, pursuant to subparagraph
30 (A), the state shall participate in that increase as provided in
31 subparagraph (A) up to the amount specified in subdivision (d) of
32 Section 12306.1.

33 (C) The county share of these expenditures shall be included in
34 the County IHSS MOE, in addition to the amount established under
35 subdivisions (b) and (c). For any increase in provider wages or
36 health benefits that becomes effective on a date other than July 1,
37 the Department of Finance shall adjust the county's County IHSS
38 MOE to reflect the annualized cost of the county's share of the
39 nonfederal cost of the wage or health benefit increase.

1 (2) (A) If the department does not approve the rates and other
 2 economic terms for a locally negotiated, mediated, or imposed
 3 increase in the provider wages, health benefits, or other economic
 4 terms pursuant to Section 12306.1 or paragraph (3), the county
 5 shall pay the entire nonfederal share of the cost increase.

6 (B) The county share of these expenditures shall be included in
 7 the County IHSS MOE, in addition to the amount established under
 8 subdivisions (b) and (c). For any increase in provider wages or
 9 health benefits that becomes effective on a date other than July 1,
 10 the Department of Finance shall adjust the county’s County IHSS
 11 MOE to reflect the annualized cost of the county’s share of the
 12 nonfederal cost of the wage or health benefit increase.

13 (3) In addition to the rate approval requirements in Section
 14 12306.1, it shall be presumed by the department that locally
 15 negotiated rates and other economic terms within the following
 16 limits are approved:

17 (A) A net increase in the combined total of wages and health
 18 benefits of up to 10 percent per year above the current combined
 19 total of wages and health benefits paid in that county.

20 (B) A cumulative total of up to 20 percent in the sum of the
 21 combined total of changes in wages or health benefits, or both,
 22 until the Statewide Authority assumes the responsibilities set forth
 23 in Section 110011 of the Government Code for a given county as
 24 provided in Section 12300.7.

25 (e) The County IHSS MOE shall only be adjusted pursuant to
 26 subdivisions (c) and (d).

27 (f) The Department of Finance shall consult with the California
 28 State Association of Counties to implement the County IHSS MOE,
 29 which shall include, but not be limited to, determining each
 30 county’s County IHSS MOE base pursuant to subdivision (b),
 31 developing the computation for the annualized amount pursuant
 32 to subdivision (d), and the process by which it will be determined
 33 that each county has met its County IHSS MOE each year.

34 ~~(g) If the demonstration project and the responsibilities of the~~
 35 ~~Statewide Authority become inoperative pursuant to Section 15,~~
 36 ~~16, or 17 of the act adding this section on a date other than July 1,~~
 37 ~~this section shall become inoperative on the first day of the~~
 38 ~~following state fiscal year.~~

39 *SEC. 13. Section 14132.275 of the Welfare and Institutions*
 40 *Code is amended to read:*

1 14132.275. (a) The department shall seek federal approval to
2 establish the demonstration project described in this section
3 pursuant to a Medicare or a Medicaid demonstration project or
4 waiver, or a combination thereof. Under a Medicare demonstration,
5 the department may contract with the federal Centers for Medicare
6 and Medicaid Services (CMS) and demonstration sites to operate
7 the Medicare and Medicaid benefits in a demonstration project
8 that is overseen by the state as a delegated Medicare benefit
9 administrator, and may enter into financing arrangements with
10 CMS to share in any Medicare program savings generated by the
11 demonstration project.

12 (b) After federal approval is obtained, the department shall
13 establish the demonstration project that enables dual eligible
14 beneficiaries to receive a continuum of services that maximizes
15 access to, and coordination of, benefits between the Medi-Cal and
16 Medicare programs and access to the continuum of long-term
17 services and supports and behavioral health services, including
18 mental health and substance use disorder treatment services. The
19 purpose of the demonstration project is to integrate services
20 authorized under the federal Medicaid Program (Title XIX of the
21 federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the
22 federal Medicare Program (Title XVIII of the federal Social
23 Security Act (42 U.S.C. Sec. 1395 et seq.)). The demonstration
24 project may also include additional services as approved through
25 a demonstration project or waiver, or a combination thereof.

26 (c) For purposes of this section, the following definitions shall
27 apply:

28 (1) “Behavioral health” means Medi-Cal services provided
29 pursuant to Section 51341 of Title 22 of the California Code of
30 Regulations and Drug Medi-Cal substance abuse services provided
31 pursuant to Section 51341.1 of Title 22 of the California Code of
32 Regulations, and any mental health benefits available under the
33 Medicare Program.

34 (2) “Capitated payment model” means an agreement entered
35 into between CMS, the state, and a managed care health plan, in
36 which the managed care health plan receives a capitation payment
37 for the comprehensive, coordinated provision of Medi-Cal services
38 and benefits under Medicare Part C (42 U.S.C. Sec. 1395w-21 et
39 seq.) and Medicare Part D (42 U.S.C. Sec. 1395w-101 et seq.),
40 and CMS shares the savings with the state from improved provision

1 of Medi-Cal and Medicare services that reduces the cost of those
2 services. Medi-Cal services include long-term services and supports
3 as defined in Section 14186.1, behavioral health services, and any
4 additional services offered by the demonstration site.

5 (3) “Demonstration site” means a managed care health plan that
6 is selected to participate in the demonstration project under the
7 capitated payment model.

8 (4) “Dual eligible beneficiary” means an individual 21 years of
9 age or older who is enrolled for benefits under Medicare Part A
10 (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C.
11 Sec. 1395j et seq.) and is eligible for medical assistance under the
12 Medi-Cal State Plan.

13 (d) No sooner than March 1, 2011, the department shall identify
14 health care models that may be included in the demonstration
15 project, shall develop a timeline and process for selecting,
16 financing, monitoring, and evaluating the demonstration sites, and
17 shall provide this timeline and process to the appropriate fiscal
18 and policy committees of the Legislature. The department may
19 implement these demonstration sites in phases.

20 (e) The department shall provide the fiscal and appropriate
21 policy committees of the Legislature with a copy of any report
22 submitted to CMS to meet the requirements under the
23 demonstration project.

24 (f) Goals for the demonstration project shall include all of the
25 following:

26 (1) Coordinate Medi-Cal and Medicare benefits across health
27 care settings and improve the continuity of care across acute care,
28 long-term care, behavioral health, including mental health and
29 substance use disorder services, and home- and community-based
30 services settings using a person-centered approach.

31 (2) Coordinate access to acute and long-term care services for
32 dual eligible beneficiaries.

33 (3) Maximize the ability of dual eligible beneficiaries to remain
34 in their homes and communities with appropriate services and
35 supports in lieu of institutional care.

36 (4) Increase the availability of and access to home- and
37 community-based services.

38 (5) Coordinate access to necessary and appropriate behavioral
39 health services, including mental health and substance use disorder
40 services.

1 (6) Improve the quality of care for dual eligible beneficiaries.

2 (7) Promote a system that is both sustainable and person and
3 family centered by providing dual eligible beneficiaries with timely
4 access to appropriate, coordinated health care services and
5 community resources that enable them to attain or maintain
6 personal health goals.

7 (g) No sooner than March 1, 2013, demonstration sites shall be
8 established in up to eight counties, and shall include at least one
9 county that provides Medi-Cal services via a two-plan model
10 pursuant to Article 2.7 (commencing with Section 14087.3) and
11 at least one county that provides Medi-Cal services under a county
12 organized health system pursuant to Article 2.8 (commencing with
13 Section 14087.5). The director shall consult with the Legislature,
14 CMS, and stakeholders when determining the implementation date
15 for this section. In determining the counties in which to establish
16 a demonstration site, the director shall consider the following:

17 (1) Local support for integrating medical care, long-term care,
18 and home- and community-based services networks.

19 (2) A local stakeholder process that includes health plans,
20 providers, mental health representatives, community programs,
21 consumers, designated representatives of in-home supportive
22 services personnel, and other interested stakeholders in the
23 development, implementation, and continued operation of the
24 demonstration site.

25 (h) In developing the process for selecting, financing,
26 monitoring, and evaluating the health care models for the
27 demonstration project, the department shall enter into a
28 memorandum of understanding with CMS. Upon completion, the
29 memorandum of understanding shall be provided to the fiscal and
30 appropriate policy committees of the Legislature and posted on
31 the department's Internet Web site.

32 (i) The department shall negotiate the terms and conditions of
33 the memorandum of understanding, which shall address, but are
34 not limited to, the following:

35 (1) Reimbursement methods for a capitated payment model.
36 Under the capitated payment model, the demonstration sites shall
37 meet all of the following requirements:

38 (A) Have Medi-Cal managed care health plan and Medicare
39 dual eligible-special needs plan contract experience, or evidence
40 of the ability to meet these contracting requirements.

1 (B) Be in good financial standing and meet licensure
2 requirements under the Knox-Keene Health Care Service Plan Act
3 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division
4 2 of the Health and Safety Code), except for county organized
5 health system plans that are exempt from licensure pursuant to
6 Section 14087.95.

7 (C) Meet quality measures, which may include Medi-Cal and
8 Medicare Healthcare Effectiveness Data and Information Set
9 measures and other quality measures determined or developed by
10 the department or CMS.

11 (D) Demonstrate a local stakeholder process that includes dual
12 eligible beneficiaries, managed care health plans, providers, mental
13 health representatives, county health and human services agencies,
14 designated representatives of in-home supportive services
15 personnel, and other interested stakeholders that advise and consult
16 with the demonstration site in the development, implementation,
17 and continued operation of the demonstration project.

18 (E) Pay providers reimbursement rates sufficient to maintain
19 an adequate provider network and ensure access to care for
20 beneficiaries.

21 (F) Follow final policy guidance determined by CMS and the
22 department with regard to reimbursement rates for providers
23 pursuant to paragraphs (4) to (7), inclusive, of subdivision (o).

24 (G) To the extent permitted under the demonstration, pay
25 noncontracted hospitals prevailing Medicare fee-for-service rates
26 for traditionally Medicare covered benefits and prevailing Medi-Cal
27 fee-for-service rates for traditionally Medi-Cal covered benefits.

28 (2) Encounter data reporting requirements for both Medi-Cal
29 and Medicare services provided to beneficiaries enrolling in the
30 demonstration project.

31 (3) Quality assurance withholding from the demonstration site
32 payment, to be paid only if quality measures developed as part of
33 the memorandum of understanding and plan contracts are met.

34 (4) Provider network adequacy standards developed by the
35 department and CMS, in consultation with the Department of
36 Managed Health Care, the demonstration site, and stakeholders.

37 (5) Medicare and Medi-Cal appeals and hearing process.

38 (6) Unified marketing requirements and combined review
39 process by the department and CMS.

1 (7) Combined quality management and consolidated reporting
2 process by the department and CMS.

3 (8) Procedures related to combined federal and state contract
4 management to ensure access, quality, program integrity, and
5 financial solvency of the demonstration site.

6 (9) To the extent permissible under federal requirements,
7 implementation of the provisions of Sections 14182.16 and
8 14182.17 that are applicable to beneficiaries simultaneously eligible
9 for full-scope benefits under Medi-Cal and the Medicare Program.

10 (10) (A) In consultation with the hospital industry, CMS
11 approval to ensure that Medicare supplemental payments for direct
12 graduate medical education and Medicare add-on payments,
13 including indirect medical education and disproportionate share
14 hospital adjustments continue to be made available to hospitals
15 for services provided under the demonstration.

16 (B) The department shall seek CMS approval for CMS to
17 continue these payments either outside the capitation rates or, if
18 contained within the capitation rates, and to the extent permitted
19 under the demonstration project, shall require demonstration sites
20 to provide this reimbursement to hospitals.

21 (11) To the extent permitted under the demonstration project,
22 the default rate for non-contracting providers of physician services
23 shall be the prevailing Medicare fee schedule for services covered
24 by the Medicare program and the prevailing Medi-Cal fee schedule
25 for services covered by the Medi-Cal program.

26 (j) (1) The department shall comply with and enforce the terms
27 and conditions of the memorandum of understanding with CMS,
28 as specified in subdivision (i). To the extent that the terms and
29 conditions do not address the specific selection, financing,
30 monitoring, and evaluation criteria listed in subdivision (i), the
31 department:

32 (A) Shall require the demonstration site to do all of the
33 following:

34 (i) Comply with additional site readiness criteria specified by
35 the department.

36 (ii) Comply with long-term services and supports requirements
37 in accordance with Article 5.7 (commencing with Section 14186).

38 (iii) To the extent permissible under federal requirements,
39 comply with the provisions of Sections 14182.16 and 14182.17

1 that are applicable to beneficiaries simultaneously eligible for
2 full-scope benefits under both Medi-Cal and the Medicare Program.

3 (iv) Comply with all transition of care requirements for Medicare
4 Part D benefits as described in Chapters 6 and 14 of the Medicare
5 Managed Care Manual, published by CMS, including transition
6 timeframes, notices, and emergency supplies.

7 (B) May require the demonstration site to forgo charging
8 premiums, coinsurance, copayments, and deductibles for Medicare
9 Part C and Medicare Part D services.

10 (2) The department shall notify the Legislature within 30 days
11 of the implementation of each provision in paragraph (1).

12 (k) The director may enter into exclusive or nonexclusive
13 contracts on a bid or negotiated basis and may amend existing
14 managed care contracts to provide or arrange for services provided
15 under this section. Contracts entered into or amended pursuant to
16 this section shall be exempt from the provisions of Chapter 2
17 (commencing with Section 10290) of Part 2 of Division 2 of the
18 Public Contract Code and Chapter 6 (commencing with Section
19 14825) of Part 5.5 of Division 3 of Title 2 of the Government
20 Code.

21 (l) (1) (A) Except for the exemptions provided for in this
22 section, the department shall enroll dual eligible beneficiaries into
23 a demonstration site unless the beneficiary makes an affirmative
24 choice to opt out of enrollment or is already enrolled on or before
25 June 1, 2013, in a managed care organization licensed under the
26 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
27 (commencing with Section 1340) of Division 2 of the Health and
28 Safety Code) that has previously contracted with the department
29 as a primary care case management plan pursuant to Article 2.9
30 (commencing with Section 14088) to provide services to
31 beneficiaries who are HIV positive or who have been diagnosed
32 with AIDS or in any entity with a contract with the department
33 pursuant to Chapter 8.75 (commencing with Section 14591).

34 (B) Dual eligible beneficiaries who opt out of enrollment into
35 a demonstration site may choose to remain enrolled in
36 fee-for-service Medicare or a Medicare Advantage plan for their
37 Medicare benefits, but shall be mandatorily enrolled into a
38 Medi-Cal managed care health plan pursuant to Section 14182.16,
39 except as exempted under subdivision (c) of Section 14182.16.

1 (C) (i) Persons meeting requirements for the Program of
2 All-Inclusive Care for the Elderly (PACE) pursuant to Chapter
3 8.75 (commencing with Section 14591) or a managed care
4 organization licensed under the Knox-Keene Health Care Service
5 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)
6 of Division 2 of the Health and Safety Code) that has previously
7 contracted with the department as a primary care case management
8 plan pursuant to Article 2.9 (commencing with Section 14088) of
9 Chapter 7 to provide services to beneficiaries who are HIV positive
10 or who have been diagnosed with AIDS may select either of these
11 managed care health plans for their Medicare and Medi-Cal benefits
12 if one is available in that county.

13 (ii) In areas where a PACE plan is available, the PACE plan
14 shall be presented as an enrollment option, included in all
15 enrollment materials, enrollment assistance programs, and outreach
16 programs related to the demonstration project, and made available
17 to beneficiaries whenever enrollment choices and options are
18 presented. Persons meeting the age qualifications for PACE and
19 who choose PACE shall remain in the fee-for-service Medi-Cal
20 and Medicare programs, and shall not be assigned to a managed
21 care health plan for the lesser of 60 days or until they are assessed
22 for eligibility for PACE and determined not to be eligible for a
23 PACE plan. Persons enrolled in a PACE plan shall receive all
24 Medicare and Medi-Cal services from the PACE program pursuant
25 to the three-way agreement between the PACE program, the
26 department, and the Centers for Medicare and Medicaid Services.

27 (2) To the extent that federal approval is obtained, the
28 department may require that any beneficiary, upon enrollment in
29 a demonstration site, remain enrolled in the Medicare portion of
30 the demonstration project on a mandatory basis for six months
31 from the date of initial enrollment. After the sixth month, a dual
32 eligible beneficiary may elect to enroll in a different demonstration
33 site, a different Medicare Advantage plan, fee-for-service Medicare,
34 PACE, or a managed care organization licensed under the
35 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
36 (commencing with Section 1340) of Division 2 of the Health and
37 Safety Code) that has previously contracted with the department
38 as a primary care case management plan pursuant to Article 2.9
39 (commencing with Section 14088) to provide services to

1 beneficiaries who are HIV positive or who have been diagnosed
2 with AIDS, for his or her Medicare benefits.

3 (A) During the six-month mandatory enrollment in a
4 demonstration site, a beneficiary may continue receiving services
5 from an out-of-network Medicare provider for primary and
6 specialty care services only if all of the following criteria are met:

7 (i) The dual eligible beneficiary demonstrates an existing
8 relationship with the provider prior to enrollment in a
9 demonstration site.

10 (ii) The provider is willing to accept payment from the
11 demonstration site based on the current Medicare fee schedule.

12 (iii) The demonstration site would not otherwise exclude the
13 provider from its provider network due to documented quality of
14 care concerns.

15 (B) The department shall develop a process to inform providers
16 and beneficiaries of the availability of continuity of services from
17 an existing provider and ensure that the beneficiary continues to
18 receive services without interruption.

19 (3) (A) Notwithstanding subparagraph (A) of paragraph (1) of
20 subdivision (l), a dual eligible beneficiary shall be excluded from
21 enrollment in the demonstration project if the beneficiary meets
22 any of the following:

23 (i) The beneficiary has a prior diagnosis of end-stage renal
24 disease. This clause shall not apply to beneficiaries diagnosed with
25 end-stage renal disease subsequent to enrollment in the
26 demonstration project. The director may, with stakeholder input
27 and federal approval, authorize beneficiaries with a prior diagnosis
28 of end-stage renal disease in specified counties to voluntarily enroll
29 in the demonstration project.

30 (ii) The beneficiary has other health coverage, as defined in
31 paragraph ~~(4)~~ (5) of subdivision (b) of Section 14182.16.

32 (iii) The beneficiary is enrolled in a home- and community-based
33 waiver that is a Medi-Cal benefit under Section 1915(c) of the
34 federal Social Security Act (42 U.S.C. Sec. 1396n et seq.), except
35 for persons enrolled in Multipurpose Senior Services Program
36 services.

37 (iv) The beneficiary is receiving services through a regional
38 center or state developmental center.

1 (v) The beneficiary resides in a geographic area or ZIP Code
2 not included in managed care, as determined by the department
3 and CMS.

4 (vi) The beneficiary resides in one of the Veterans' Homes of
5 California, as described in Chapter 1 (commencing with Section
6 1010) of Division 5 of the Military and Veterans Code.

7 (B) (i) Beneficiaries who have been diagnosed with HIV/AIDS
8 may opt out of the demonstration project at the beginning of any
9 month. The State Department of Public Health may share relevant
10 data relating to a beneficiary's enrollment in the AIDS Drug
11 Assistance Program with the department, and the department may
12 share relevant data relating to HIV-positive beneficiaries with the
13 State Department of Public Health.

14 (ii) The information provided by the State Department of Public
15 Health pursuant to this subparagraph shall not be further disclosed
16 by the State Department of Health Care Services, and shall be
17 subject to the confidentiality protections of subdivisions (d) and
18 (e) of Section 121025 of the Health and Safety Code, except this
19 information may be further disclosed as follows:

20 (I) To the person to whom the information pertains or the
21 designated representative of that person.

22 (II) To the Office of AIDS within the State Department of Public
23 Health.

24 (C) Beneficiaries who are Indians receiving Medi-Cal services
25 in accordance with Section 55110 of Title 22 of the California
26 Code of Regulations may opt out of the demonstration project at
27 the beginning of any month.

28 (D) The department, with stakeholder input, may exempt specific
29 categories of dual eligible beneficiaries from enrollment
30 requirements in this section based on extraordinary medical needs
31 of specific patient groups or to meet federal requirements.

32 (4) For the 2013 calendar year, the department shall offer federal
33 Medicare Improvements for Patients and Providers Act of 2008
34 (Public Law 110-275) compliant contracts to existing Medicare
35 Advantage Special Needs Plans (D-SNP plans) to continue to
36 provide Medicare benefits to their enrollees in their service areas
37 as approved on January 1, 2012. In the 2013 calendar year,
38 beneficiaries in Medicare Advantage and D-SNP plans shall be
39 exempt from the enrollment provisions of subparagraph (A) of
40 paragraph (1), but may voluntarily choose to enroll in the

1 demonstration project. Enrollment into the demonstration project's
2 managed care health plans shall be reassessed in 2014 depending
3 on federal reauthorization of the D-SNP model and the
4 department's assessment of the demonstration plans.

5 (5) For the 2013 calendar year, demonstration sites shall not
6 offer to enroll dual eligible beneficiaries eligible for the
7 demonstration project into the demonstration site's D-SNP.

8 (6) The department shall not terminate contracts in a
9 demonstration site with a managed care organization licensed
10 under the Knox-Keene Health Care Service Plan Act of 1975
11 (Chapter 2.2 (commencing with Section 1340) of Division 2 of
12 the Health and Safety Code) that has previously contracted with
13 the department as a primary care case management plan pursuant
14 to Article 2.9 (commencing with Section 14088) to provide services
15 to beneficiaries who are HIV positive beneficiaries or who have
16 been diagnosed with AIDS and with any entity with a contract
17 pursuant to Chapter 8.75 (commencing with Section 14591), except
18 as provided in the contract or pursuant to state or federal law.

19 (m) Notwithstanding Section 10231.5 of the Government Code,
20 the department shall conduct an evaluation, in partnership with
21 CMS, to assess outcomes and the experience of dual eligibles in
22 these demonstration sites and shall provide a report to the
23 Legislature after the first full year of demonstration operation, and
24 annually thereafter. A report submitted to the Legislature pursuant
25 to this subdivision shall be submitted in compliance with Section
26 9795 of the Government Code. The department shall consult with
27 stakeholders regarding the scope and structure of the evaluation.

28 (n) This section shall be implemented only if and to the extent
29 that federal financial participation or funding is available.

30 (o) It is the intent of the Legislature that:

31 (1) In order to maintain adequate provider networks,
32 demonstration sites shall reimburse providers at rates sufficient to
33 ensure access to care for beneficiaries.

34 (2) Savings under the demonstration project are intended to be
35 achieved through shifts in utilization, and not through reduced
36 reimbursement rates to providers.

37 (3) Reimbursement policies shall not prevent demonstration
38 sites and providers from entering into payment arrangements that
39 allow for the alignment of financial incentives and provide
40 opportunities for shared risk and shared savings in order to promote

1 appropriate utilization shifts, which encourage the use of home-
2 and community-based services and quality of care for dual eligible
3 beneficiaries enrolled in the demonstration sites.

4 (4) To the extent permitted under the demonstration project,
5 and to the extent that a public entity voluntarily provides an
6 intergovernmental transfer for this purpose, both of the following
7 shall apply:

8 (A) The department shall work with CMS in ensuring that the
9 capitation rates under the demonstration project are inclusive of
10 funding currently provided through certified public expenditures
11 supplemental payment programs that would otherwise be impacted
12 by the demonstration project.

13 (B) Demonstration sites shall pay to a public entity voluntarily
14 providing intergovernmental transfers that previously received
15 reimbursement under a certified public expenditures supplemental
16 payment program, rates that include the additional funding under
17 the capitation rates that are funded by the public entity's
18 intergovernmental transfer.

19 (5) The department shall work with CMS in developing other
20 reimbursement policies and shall inform demonstration sites,
21 providers, and the Legislature of the final policy guidance.

22 (6) The department shall seek approval from CMS to permit
23 the provider payment requirements contained in subparagraph (G)
24 of paragraph (1) and paragraphs (10) and (11) of subdivision (i),
25 and Section 14132.276.

26 (7) Demonstration sites that contract with hospitals for hospital
27 services on a fee-for-service basis that otherwise would have been
28 traditionally Medicare services will achieve savings through
29 utilization changes and not by paying hospitals at rates lower than
30 prevailing Medicare fee-for-service rates.

31 (p) The department shall enter into an interagency agreement
32 with the Department of Managed Health Care to perform some or
33 all of the department's oversight and readiness review activities
34 specified in this section. These activities may include providing
35 consumer assistance to beneficiaries affected by this section and
36 conducting financial audits, medical surveys, and a review of the
37 adequacy of provider networks of the managed care health plans
38 participating in this section. The interagency agreement shall be
39 updated, as necessary, on an annual basis in order to maintain
40 functional clarity regarding the roles and responsibilities of the

1 Department of Managed Health Care and the department. The
2 department shall not delegate its authority under this section as
3 the single state Medicaid agency to the Department of Managed
4 Health Care.

5 (q) (1) Beginning with the May Revision to the 2013–14
6 Governor’s Budget, and annually thereafter, the department shall
7 report to the Legislature on the enrollment status, quality measures,
8 and state costs of the actions taken pursuant to this section.

9 (2) (A) By January 1, 2013, or as soon thereafter as practicable,
10 the department shall develop, in consultation with CMS and
11 stakeholders, quality and fiscal measures for health plans to reflect
12 the short- and long-term results of the implementation of this
13 section. The department shall also develop quality thresholds and
14 milestones for these measures. The department shall update these
15 measures periodically to reflect changes in this program due to
16 implementation factors and the structure and design of the benefits
17 and services being coordinated by managed care health plans.

18 (B) The department shall require health plans to submit
19 Medicare and Medi-Cal data to determine the results of these
20 measures. If the department finds that a health plan is not in
21 compliance with one or more of the measures set forth in this
22 section, the health plan shall, within 60 days, submit a corrective
23 action plan to the department for approval. The corrective action
24 plan shall, at a minimum, include steps that the health plan shall
25 take to improve its performance based on the standard or standards
26 with which the health plan is out of compliance. The plan shall
27 establish interim benchmarks for improvement that shall be
28 expected to be met by the health plan in order to avoid a sanction
29 pursuant to Section 14304. Nothing in this subparagraph is intended
30 to limit Section 14304.

31 (C) The department shall publish the results of these measures,
32 including via posting on the department’s Internet Web site, on a
33 quarterly basis.

34 (r) Notwithstanding Chapter 3.5 (commencing with Section
35 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
36 the department may implement, interpret, or make specific this
37 section and any applicable federal waivers and state plan
38 amendments by means of all-county letters, plan letters, plan or
39 provider bulletins, or similar instructions, without taking regulatory
40 action. Prior to issuing any letter or similar instrument authorized

1 pursuant to this section, the department shall notify and consult
2 with stakeholders, including advocates, providers, and
3 beneficiaries. The department shall notify the appropriate policy
4 and fiscal committees of the Legislature of its intent to issue
5 instructions under this section at least five days in advance of the
6 issuance.

7 *(s) This section shall be inoperative if the Coordinated Care*
8 *Initiative becomes inoperative pursuant to Section 34 of the act*
9 *that added this subdivision.*

10 SEC. 14. Section 14132.275 is added to the Welfare and
11 Institutions Code, to read:

12 14132.275. (a) *The department shall seek federal approval to*
13 *establish pilot projects described in this section pursuant to a*
14 *Medicare or a Medicaid demonstration project or waiver, or a*
15 *combination thereof. Under a Medicare demonstration, the*
16 *department may operate the Medicare component of a pilot project*
17 *as a delegated Medicare benefit administrator, and may enter into*
18 *financing arrangements with the federal Centers for Medicare and*
19 *Medicaid Services to share in any Medicare program savings*
20 *generated by the operation of any pilot project.*

21 (b) *After federal approval is obtained, the department shall*
22 *establish pilot projects that enable dual eligibles to receive a*
23 *continuum of services, and that maximize the coordination of*
24 *benefits between the Medi-Cal and Medicare programs and access*
25 *to the continuum of services needed. The purpose of the pilot*
26 *projects is to develop effective health care models that integrate*
27 *services authorized under the federal Medicaid Program (Title*
28 *XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.))*
29 *and the federal Medicare Program (Title XVIII of the federal Social*
30 *Security Act (42 U.S.C. Sec. 1395 et seq.)). These pilot projects*
31 *may also include additional services as approved through a*
32 *demonstration project or waiver, or a combination thereof.*

33 (c) *Not sooner than March 1, 2011, the department shall identify*
34 *health care models that may be included in a pilot project, shall*
35 *develop a timeline and process for selecting, financing, monitoring,*
36 *and evaluating these pilot projects, and shall provide this timeline*
37 *and process to the appropriate fiscal and policy committees of the*
38 *Legislature. The department may implement these pilot projects*
39 *in phases.*

40 (d) *Goals for the pilot projects shall include all of the following:*

1 (1) *Coordinating Medi-Cal benefits, Medicare benefits, or both,*
2 *across health care settings and improving continuity of acute care,*
3 *long-term care, and home- and community-based services.*

4 (2) *Coordinating access to acute and long-term care services*
5 *for dual eligibles.*

6 (3) *Maximizing the ability of dual eligibles to remain in their*
7 *homes and communities with appropriate services and supports*
8 *in lieu of institutional care.*

9 (4) *Increasing the availability of and access to home- and*
10 *community-based alternatives.*

11 (e) *Pilot projects shall be established in up to four counties,*
12 *and shall include at least one county that provides Medi-Cal*
13 *services via a two-plan model pursuant to Article 2.7 (commencing*
14 *with Section 14087.3) and at least one county that provides*
15 *Medi-Cal services under a county organized health system pursuant*
16 *to Article 2.8 (commencing with Section 14087.5). In determining*
17 *the counties in which to establish a pilot project, the director shall*
18 *consider the following:*

19 (1) *Local support for integrating medical care, long-term care,*
20 *and home- and community-based services networks.*

21 (2) *A local stakeholder process that includes health plans,*
22 *providers, community programs, consumers, and other interested*
23 *stakeholders in the development, implementation, and continued*
24 *operation of the pilot project.*

25 (f) *The director may enter into exclusive or nonexclusive*
26 *contracts on a bid or negotiated basis and may amend existing*
27 *managed care contracts to provide or arrange for services*
28 *provided under this section. Contracts entered into or amended*
29 *pursuant to this section shall be exempt from the provisions of*
30 *Chapter 2 (commencing with Section 10290) of Part 2 of Division*
31 *2 of the Public Contract Code and Chapter 6 (commencing with*
32 *Section 14825) of Part 5.5 of Division 3 of Title 2 of the*
33 *Government Code.*

34 (g) *Services under Section 14132.95 or 14132.952, or Article*
35 *7 (commencing with Section 12300) of Chapter 3 that are provided*
36 *under the pilot projects established by this section shall be provided*
37 *through direct hiring of personnel, contract, or establishment of*
38 *a public authority or nonprofit consortium, in accordance with,*
39 *and subject to, Section 12302 or 12301.6, as applicable.*

1 (h) Notwithstanding any other provision of state law, the
2 department may require that dual eligibles be assigned as
3 mandatory enrollees into managed care plans established or
4 expanded as part of a pilot project established under this section.
5 Mandatory enrollment in managed care for dual eligibles shall be
6 applicable to the beneficiary's Medi-Cal benefits only. Dual
7 eligibles shall have the option to enroll in a Medicare Advantage
8 special needs plan (SNP) offered by the managed care plan
9 established or expanded as part of a pilot project established
10 pursuant to subdivision (e). To the extent that mandatory
11 enrollment is required, any requirement of the department and the
12 health plans, and any requirement of continuity of care protections
13 for enrollees, as specified in Section 14182, shall be applicable to
14 this section. Dual eligibles shall have the option to forgo receiving
15 Medicare benefits under a pilot project. Nothing in this section
16 shall be interpreted to reduce benefits otherwise available under
17 the Medi-Cal program or the Medicare Program.

18 (i) For purposes of this section, a "dual eligible" means an
19 individual who is simultaneously eligible for full scope benefits
20 under Medi-Cal and the federal Medicare Program.

21 (j) Persons meeting requirements for the Program of
22 All-Inclusive Care for the Elderly (PACE) pursuant to Chapter
23 8.75 (commencing with Section 14591), may select a PACE plan
24 if one is available in that county.

25 (k) Notwithstanding Section 10231.5 of the Government Code,
26 the department shall conduct an evaluation to assess outcomes
27 and the experience of dual eligibles in these pilot projects and
28 shall provide a report to the Legislature after the first full year of
29 pilot operation, and annually thereafter. A report submitted to the
30 Legislature pursuant to this subdivision shall be submitted in
31 compliance with Section 9795 of the Government Code. The
32 department shall consult with stakeholders regarding the scope
33 and structure of the evaluation.

34 (l) This section shall be implemented only if and to the extent
35 that federal financial participation or funding is available to
36 establish these pilot projects.

37 (m) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department may implement, interpret, or make specific this
40 section and any applicable federal waivers and state plan

1 amendments by means of all-county letters, plan letters, plan or
2 provider bulletins, or similar instructions, without taking
3 regulatory action. Prior to issuing any letter or similar instrument
4 authorized pursuant to this section, the department shall notify
5 and consult with stakeholders, including advocates, providers,
6 and beneficiaries. The department shall notify the appropriate
7 policy and fiscal committees of the Legislature of its intent to issue
8 instructions under this section at least five days in advance of the
9 issuance.

10 (n) This section shall be operative only if Section 13 of the act
11 that added this section becomes inoperative pursuant to subdivision
12 (s) of that Section 13.

13 SEC. 15. Section 14132.277 is added to the Welfare and
14 Institutions Code, to read:

15 14132.277. (a) For purposes of this section, the following
16 definitions shall apply:

17 (1) “Coordinated Care Initiative county” means the Counties
18 of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San
19 Diego, San Mateo, and Santa Clara, and any other county
20 identified in Appendix 3 of the memorandum of understanding
21 between the state and the Centers for Medicare and Medicaid
22 Services Regarding A Federal-State Partnership to Test a
23 Capitated Financial Alignment Model for Medicare-Medicaid
24 Enrollees, inclusive of all amendments, as authorized by Section
25 14132.275.

26 (2) “D-SNP plan” means a Medicare Advantage Special Needs
27 Plan.

28 (3) “D-SNP contract” means a federal Medicare Improvements
29 for Patients and Provider Act of 2008 (Public Law 110-275)
30 compliant contract between the department and a D-SNP plan.

31 (b) For calendar year 2014, the department shall offer D-SNP
32 contracts to existing D-SNP plans to continue to provide benefits
33 to their enrollees in their service areas as approved on January
34 1, 2013. The director may include in any D-SNP contract
35 provisions requiring that the D-SNP plan do the following:

36 (1) Submit to the department a complete and accurate copy of
37 the bid submitted by the plan to the Centers for Medicare and
38 Medicaid Services for its D-SNP contract.

1 (2) *Submit to the department copies of all utilization and quality*
2 *management reports submitted to the Centers for Medicare and*
3 *Medicaid Services.*

4 (c) *In Coordinated Care Initiative counties, Medicare Advantage*
5 *Plans and D-SNP plans may continue to enroll beneficiaries in*
6 *2014. In the 2014 calendar year, beneficiaries enrolled in a*
7 *Medicare Advantage or D-SNP plan operating in a Coordinated*
8 *Care Initiative county shall be exempt from the enrollment*
9 *provisions of subparagraph (A) of paragraph (1) of subdivision*
10 *(l) of Section 14132.275. Those beneficiaries may at any time*
11 *voluntarily choose to disenroll from their Medicare Advantage or*
12 *D-SNP plan and enroll in a demonstration site operating pursuant*
13 *to subdivision (g) of Section 14132.275. If a beneficiary chooses*
14 *to do so, that beneficiary may subsequently disenroll from the*
15 *demonstration site and return to fee-for-service Medicare or to a*
16 *D-SNP plan or Medicare Advantage plan.*

17 SEC. 16. *Section 14182.16 of the Welfare and Institutions Code*
18 *is amended to read:*

19 14182.16. (a) The department shall require Medi-Cal
20 beneficiaries who have dual eligibility in Medi-Cal and the
21 Medicare Program to be assigned as mandatory enrollees into new
22 or existing Medi-Cal managed care health plans for their Medi-Cal
23 benefits ~~in counties participating in the demonstration project~~
24 ~~pursuant to Section 14132.275~~ *Coordinated Care Initiative*
25 *counties.*

26 (b) For the purposes of this section and Section 14182.17, the
27 following definitions shall apply:

28 (1) *“Coordinated Care Initiative counties” means the Counties*
29 *of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San*
30 *Diego, San Mateo, and Santa Clara.*

31 (1)

32 (2) *“Dual eligible beneficiary” means an individual 21 years of*
33 *age or older who is enrolled for benefits under Medicare Part A*
34 *(42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec.*
35 *1395j et seq.), or both, and is eligible for medical assistance under*
36 *the Medi-Cal State Plan.*

37 (2)

38 (3) *“Full-benefit dual eligible beneficiary” means an individual*
39 *21 years of age or older who is eligible for benefits under Medicare*
40 *Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C.*

1 Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec.
2 1395w-101), and is eligible for medical assistance under the
3 Medi-Cal State Plan.

4 ~~(3)~~

5 (4) “Managed care health plan” means an individual,
6 organization, or entity that enters into a contract with the
7 department pursuant to Article 2.7 (commencing with Section
8 14087.3), Article 2.81 (commencing with Section 14087.96), or
9 Article 2.91 (commencing with Section 14089), of this chapter,
10 or Chapter 8 (commencing with Section 14200).

11 ~~(4)~~

12 (5) “Other health coverage” means health coverage providing
13 the same full or partial benefits as the Medi-Cal program, health
14 coverage under another state or federal medical care program
15 except for the Medicare Program (Title XVIII of the federal Social
16 Security Act (42 U.S.C. Sec. 1395 et seq.)), or health coverage
17 under a contractual or legal entitlement, including, but not limited
18 to, a private group or indemnification insurance program.

19 ~~(5)~~

20 (6) “Out-of-network Medi-Cal provider” means a health care
21 provider that does not have an existing contract with the
22 beneficiary’s managed care health plan or its subcontractors.

23 ~~(6)~~

24 (7) “Partial-benefit dual eligible beneficiary” means an
25 individual 21 years of age or older who is enrolled for benefits
26 under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not
27 Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is eligible
28 for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not
29 Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for
30 medical assistance under the Medi-Cal State Plan.

31 (c) (1) Notwithstanding subdivision (a), a dual eligible
32 beneficiary is exempt from mandatory enrollment in a managed
33 care health plan if the dual eligible beneficiary meets any of the
34 following:

35 (A) Except in counties with county organized health systems
36 operating pursuant to Article 2.8 (commencing with Section
37 14087.5), the beneficiary has other health coverage.

38 (B) The beneficiary receives services through a foster care
39 program, including the program described in Article 5
40 (commencing with Section 11400) of Chapter 2.

1 (C) The beneficiary is under 21 years of age.

2 (D) The beneficiary is not eligible for enrollment in managed
3 care health plans for medically necessary reasons determined by
4 the department.

5 (E) The beneficiary resides in one of the Veterans Homes of
6 California, as described in Chapter 1 (commencing with Section
7 1010) of Division 5 of the Military and Veterans Code.

8 (F) The beneficiary is enrolled in any entity with a contract with
9 the department pursuant to Chapter 8.75 (commencing with Section
10 14591).

11 (G) The beneficiary is enrolled in a managed care organization
12 licensed under the Knox-Keene Health Care Service Plan Act of
13 1975 (Chapter 2.2 (commencing with Section 1340) of Division
14 2 of the Health and Safety Code) that has previously contracted
15 with the department as a primary care case management plan
16 pursuant to Article 2.9 (commencing with Section 14088) of
17 Chapter 7.

18 (2) A beneficiary who has been diagnosed with HIV/AIDS is
19 not exempt from mandatory enrollment, but may opt out of
20 managed care enrollment at the beginning of any month.

21 (d) Implementation of this section shall incorporate the
22 provisions of Section 14182.17 that are applicable to beneficiaries
23 eligible for benefits under Medi-Cal and the Medicare Program.

24 (e) At the director's sole discretion, in consultation with
25 stakeholders, the department may determine and implement a
26 phased-in enrollment approach that may include Medi-Cal
27 beneficiary enrollment into managed care health plans immediately
28 upon implementation of this section in a specific county, over a
29 12-month period, or other phased approach. The phased-in
30 enrollment shall commence no sooner than March 1, 2013, and
31 not until all necessary federal approvals have been obtained.

32 (f) To the extent that mandatory enrollment is required by the
33 department, an enrollee's access to fee-for-service Medi-Cal shall
34 not be terminated until the enrollee has selected or been assigned
35 to a managed care health plan.

36 (g) Except in a county where Medi-Cal services are provided
37 by a county organized health system, and notwithstanding any
38 other law, in any county in which fewer than two existing managed
39 health care plans contract with the department to provide Medi-Cal
40 services under this chapter that are available to dual eligible

1 beneficiaries, including long-term services and supports, the
2 department may contract with additional managed care health plans
3 to provide Medi-Cal services.

4 (h) For partial-benefit dual eligible beneficiaries, the department
5 shall inform these beneficiaries of their rights to continuity of care
6 from out-of-network Medi-Cal providers pursuant to subparagraph
7 (G) of paragraph (5) of subdivision (d) of Section 14182.17, and
8 that the need for medical exemption criteria applied to counties
9 operating under Chapter 4.1 (commencing with Section 53800) of
10 Subdivision 1 of Division 3 of Title 22 of the California Code of
11 Regulations may not be necessary to continue receiving Medi-Cal
12 services from an out-of-network provider.

13 (i) The department may contract with existing managed care
14 health plans to provide or arrange for services under this section.
15 Notwithstanding any other law, the department may enter into the
16 contract without the need for a competitive bid process or other
17 contract proposal process, provided that the managed care health
18 plan provides written documentation that it meets all of the
19 qualifications and requirements of this section and Section
20 14182.17.

21 (j) The development of capitation rates for managed care health
22 plan contracts shall include the analysis of data specific to the dual
23 eligible population. For the purposes of developing capitation rates
24 for payments to managed care health plans, the department shall
25 require all managed care health plans, including existing managed
26 care health plans, to submit financial, encounter, and utilization
27 data in a form, at a time, and including substance as deemed
28 necessary by the department. Failure to submit the required data
29 shall result in the imposition of penalties pursuant to Section
30 14182.1.

31 (k) Persons meeting participation requirements for the Program
32 of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter
33 8.75 (commencing with Section 14591) may select a PACE plan
34 if one is available in that county.

35 (l) Except for dual eligible beneficiaries participating in the
36 demonstration project pursuant to Section 14132.275, persons
37 meeting the participation requirements in effect on January 1,
38 2010, for a Medi-Cal primary case management plan in operation
39 on that date, may select that primary care case management plan
40 or a successor health care plan that is licensed pursuant to the

1 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
2 (commencing with Section 1340) of Division 2 of the Health and
3 Safety Code) to provide services within the same geographic area
4 that the primary care case management plan served on January 1,
5 2010.

6 (m) The department may implement an intergovernmental
7 transfer arrangement with a public entity that elects to transfer
8 public funds to the state to be used solely as the nonfederal share
9 of Medi-Cal payments to managed care health plans for the
10 provision of services to dual eligible beneficiaries pursuant to
11 Section 14182.15.

12 (n) To implement this section, the department may contract with
13 public or private entities. Contracts or amendments entered into
14 under this section may be on an exclusive or nonexclusive basis
15 and on a noncompetitive bid basis and shall be exempt from all of
16 the following:

17 (1) Part 2 (commencing with Section 10100) of Division 2 of
18 the Public Contract Code and any policies, procedures, or
19 regulations authorized by that part.

20 (2) Article 4 (commencing with Section 19130) of Chapter 5
21 of Part 2 of Division 5 of Title 2 of the Government Code.

22 (3) Review or approval of contracts by the Department of
23 General Services.

24 (o) Any otherwise applicable provisions of this chapter, Chapter
25 8 (commencing with Section 14200), or Chapter 8.75 (commencing
26 with Section 14591) not in conflict with this section or with the
27 Special Terms and Conditions of the waiver shall apply to this
28 section.

29 (p) The department shall, in coordination with and consistent
30 with an interagency agreement with the Department of Managed
31 Health Care, at a minimum, monitor on a quarterly basis the
32 adequacy of provider networks of the managed care health plans.

33 (q) The department shall suspend new enrollment of dual eligible
34 beneficiaries into a managed care health plan if it determines that
35 the managed care health plan does not have sufficient primary or
36 specialty care providers and long-term service and supports to
37 meet the needs of its enrollees.

38 (r) Managed care health plans shall pay providers in accordance
39 with Medicare and Medi-Cal coordination of benefits.

1 (s) This section shall be implemented only to the extent that all
2 federal approvals and waivers are obtained and only if and to the
3 extent that federal financial participation is available.

4 (t) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 the department may implement, interpret, or make specific this
7 section and any applicable federal waivers and state plan
8 amendments by means of all-county letters, plan letters, plan or
9 provider bulletins, or similar instructions, without taking regulatory
10 action. Prior to issuing any letter or similar instrument authorized
11 pursuant to this section, the department shall notify and consult
12 with stakeholders, including advocates, providers, and
13 beneficiaries. The department shall notify the appropriate policy
14 and fiscal committees of the Legislature of its intent to issue
15 instructions under this section at least five days in advance of the
16 issuance.

17 (u) A managed care health plan that contracts with the
18 department for the provision of services under this section shall
19 ensure that beneficiaries have access to the same categories of
20 licensed providers that are available under fee-for-service
21 Medicare. Nothing in this section shall prevent a managed care
22 health plan from contracting with selected providers within a
23 category of licensure.

24 (v) *The department shall, commencing August 1, 2013, convene*
25 *stakeholders, at least quarterly, to review progress on the*
26 *Coordinated Care Initiative and make recommendations to the*
27 *department and the Legislature for the duration of the Coordinated*
28 *Care Initiative. The stakeholders shall include beneficiaries,*
29 *counties, and health plans, and representatives from primary care*
30 *providers, specialists, hospitals, nursing facilities, MSSP programs,*
31 *CBAS programs, other social service providers, the IHSS program,*
32 *behavioral health providers, and substance use disorders*
33 *stakeholders.*

34 *SEC. 17. Section 14182.17 of the Welfare and Institutions Code*
35 *is amended to read:*

36 14182.17. (a) For the purposes of this section, the definitions
37 in subdivision (b) of Section 14182.16 shall apply.

38 (b) The department shall ensure and improve the care
39 coordination and integration of health care services for Medi-Cal
40 beneficiaries residing in *Coordinated Care Initiative* counties

1 ~~participating in the demonstration project pursuant to Section~~
2 ~~14132.275~~ who are either of the following:

3 (1) Dual eligible beneficiaries, as defined in subdivision (b) of
4 Section 14182.16, who receive Medi-Cal benefits and services
5 through the demonstration project established pursuant to Section
6 14132.275 or through mandatory enrollment in managed care
7 health plans pursuant to Section 14182.16.

8 (2) Medi-Cal beneficiaries who receive long-term services and
9 supports pursuant to Article 5.7 (commencing with Section 14186).

10 (c) The department shall develop an enrollment process to be
11 ~~used in counties participating in the demonstration project pursuant~~
12 ~~to Section 14132.275~~ *Coordinated Care Initiative counties* to do
13 the following:

14 (1) Except in a county that provides Medi-Cal services under a
15 county organized health system pursuant to Article 2.8
16 (commencing with Section 14087.5), provide a choice of Medi-Cal
17 managed care plans to a dual eligible beneficiary who has opted
18 for Medicare fee-for-service, and establish an algorithm to assign
19 beneficiaries who do not make a choice.

20 (2) Ensure that only beneficiaries required to make a choice or
21 affirmatively opt out are sent enrollment materials.

22 (3) Establish enrollment timelines, developed in consultation
23 with health plans and stakeholders, and approved by CMS, for
24 each demonstration site. The timeline may provide for combining
25 or phasing in enrollment for Medicare and Medi-Cal benefits.

26 (d) Before the department contracts with managed care health
27 plans or Medi-Cal providers to furnish Medi-Cal benefits and
28 services pursuant to subdivision (b), the department shall do all of
29 the following:

30 (1) Ensure timely and appropriate communications with
31 beneficiaries as follows:

32 (A) At least 90 days prior to enrollment, inform dual eligible
33 beneficiaries through a notice written at not more than a sixth-grade
34 reading level that includes, at a minimum, how the Medi-Cal
35 system of care will change, when the changes will occur, and who
36 they can contact for assistance with choosing a managed care health
37 plan or with problems they encounter.

38 (B) Develop and implement an outreach and education program
39 for beneficiaries to inform them of their enrollment options and

1 rights, including specific steps to work with consumer and
2 beneficiary community groups.

3 (C) Develop, in consultation with consumers, beneficiaries, and
4 other stakeholders, an overall communications plan that includes
5 all aspects of developing beneficiary notices.

6 (D) Ensure that managed care health plans and their provider
7 networks are able to provide communication and services to dual
8 eligible beneficiaries in alternative formats that are culturally,
9 linguistically, and physically appropriate through means, including,
10 but not limited to, assistive listening systems, sign language
11 interpreters, captioning, written communication, plain language,
12 and written translations.

13 (E) Ensure that managed care health plans have prepared
14 materials to inform beneficiaries of procedures for obtaining
15 Medi-Cal benefits, including grievance and appeals procedures,
16 that are offered by the plan or are available through the Medi-Cal
17 program.

18 (F) Ensure that managed care health plans have policies and
19 procedures in effect to address the effective transition of
20 beneficiaries from Medicare Part D plans not participating in the
21 demonstration project. These policies shall include, but not be
22 limited to, the transition of care requirements for Medicare Part D
23 benefits as described in Chapters 6 and 14 of the Medicare
24 Managed Care Manual, published by CMS, including a
25 determination of which beneficiaries require information about
26 their transition supply, and, within the first 90 days of coverage
27 under a new plan, provide for a temporary fill when the beneficiary
28 requests a refill of a nonformulary drug.

29 (G) Contingent upon available private or public funds other
30 than moneys from the General Fund, contract with
31 community-based, nonprofit consumer, or health insurance
32 assistance organizations with expertise and experience in assisting
33 dual eligible beneficiaries in understanding their health care
34 coverage options.

35 (H) Develop, with stakeholder input, informing and enrollment
36 materials and an enrollment process in the demonstration site
37 counties. The department shall ensure all of the following prior to
38 implementing enrollment:

39 (i) Enrollment materials shall be made public at least 60 days
40 prior to the first mailing of notices to dual eligible beneficiaries,

1 and the department shall work with stakeholders to incorporate
2 public comment into the materials.

3 (ii) The materials shall be in a not more than sixth grade reading
4 level and shall be available in all the Medi-Cal threshold languages,
5 as well as in alternative formats that are culturally, linguistically,
6 and physically appropriate. For in-person enrollment assistance,
7 disability accommodation shall be provided, when appropriate,
8 through means including, but not limited to, assistive listening
9 systems, sign language interpreters, captioning, and written
10 communication.

11 (iii) The materials shall plainly state that the beneficiary may
12 choose fee-for-service Medicare or Medicare Advantage, but must
13 return the form to indicate this choice, and that if the beneficiary
14 does not return the form, the state shall assign the beneficiary to
15 a plan and all Medicare and Medi-Cal benefits shall only be
16 available through that plan.

17 (iv) The materials shall plainly state that the beneficiary shall
18 be enrolled in a Medi-Cal managed care health plan even if he or
19 she chooses to stay in fee-for-service Medicare.

20 (v) The materials shall plainly explain all of the following:

21 (I) The plan choices.

22 (II) Continuity of care provisions.

23 (III) How to determine which providers are enrolled in each
24 plan.

25 (IV) How to obtain assistance with the choice forms.

26 (vi) The enrollment contractor recognizes, in compliance with
27 existing statutes and regulations, authorized representatives,
28 including, but not limited to, a caregiver, family member,
29 conservator, or a legal services advocate, who is recognized by
30 any of the services or programs that the person is already receiving
31 or participating in.

32 (I) Make available to the public and to all Medi-Cal providers
33 copies of all beneficiary notices in advance of the date the notices
34 are sent to beneficiaries. These copies shall be available on the
35 department's Internet Web site.

36 (2) Require that managed care health plans perform an
37 assessment process that, at a minimum, does all of the following:

38 (A) Assesses each new enrollee's risk level and needs by
39 performing a risk assessment process using means such as
40 telephonic, Web-based, or in-person communication, or review of

1 utilization and claims processing data, or by other means as
2 determined by the department, with a particular focus on
3 identifying those enrollees who may need long-term services and
4 supports. The risk assessment process shall be performed in
5 accordance with all applicable federal and state laws.

6 (B) Assesses the care needs of dual eligible beneficiaries and
7 coordinates their Medi-Cal benefits across all settings, including
8 coordination of necessary services within, and, when necessary,
9 outside of the managed care health plan's provider network.

10 (C) Uses a mechanism or algorithm developed by the managed
11 care health plan pursuant to paragraph (7) of subdivision (b) of
12 Section 14182 for risk stratification of members.

13 (D) At the time of enrollment, applies the risk stratification
14 mechanism or algorithm approved by the department to determine
15 the health risk level of members.

16 (E) Reviews historical Medi-Cal fee-for-service utilization data
17 and Medicare data, to the extent either is accessible to and provided
18 by the department, for dual eligible beneficiaries upon enrollment
19 in a managed care health plan so that the managed care health
20 plans are better able to assist dual eligible beneficiaries and
21 prioritize assessment and care planning.

22 (F) Analyzes Medicare claims data for dual eligible beneficiaries
23 upon enrollment in a demonstration site pursuant to Section
24 14132.275 to provide an appropriate transition process for newly
25 enrolled beneficiaries who are prescribed Medicare Part D drugs
26 that are not on the demonstration site's formulary, as required
27 under the transition of care requirements for Medicare Part D
28 benefits as described in Chapters 6 and 14 of the Medicare
29 Managed Care Manual, published by CMS.

30 (G) Assesses each new enrollee's behavioral health needs and
31 historical utilization, including mental health and substance use
32 disorder treatment services.

33 (H) Follows timeframes for reassessment and, if necessary,
34 circumstances or conditions that require redetermination of risk
35 level, which shall be set by the department.

36 (3) Ensure that the managed care health plans arrange for
37 primary care by doing all of the following:

38 (A) Except for beneficiaries enrolled in the demonstration
39 project pursuant to Section 14132.275, forgo interference with a
40 beneficiary's choice of primary care physician under Medicare,

1 and not assign a full-benefit dual eligible beneficiary to a primary
2 care physician unless it is determined through the risk stratification
3 and assessment process that assignment is necessary, in order to
4 properly coordinate the care of the beneficiary or upon the
5 beneficiary's request.

6 (B) Assign a primary care physician to a partial-benefit dual
7 eligible beneficiary receiving primary or specialty care through
8 the Medi-Cal managed care plan.

9 (C) Provide a mechanism for partial-benefit dual eligible
10 enrollees to request a specialist or clinic as a primary care provider
11 if these services are being provided through the Medi-Cal managed
12 care health plan. A specialist or clinic may serve as a primary care
13 provider if the specialist or clinic agrees to serve in a primary care
14 provider role and is qualified to treat the required range of
15 conditions of the enrollees.

16 (4) Ensure that the managed care health plans perform, at a
17 minimum, and in addition to, other statutory and contractual
18 requirements, care coordination, and care management activities
19 as follows:

20 (A) Reflect a member-centered, outcome-based approach to
21 care planning, consistent with the CMS model of care approach
22 and with federal Medicare requirements and guidance.

23 (B) Adhere to a beneficiary's determination about the
24 appropriate involvement of his or her medical providers and
25 caregivers, according to the federal Health Insurance Portability
26 and Accountability Act of 1996 (Public Law 104-191).

27 (C) Develop care management and care coordination for the
28 beneficiary across the medical and long-term services and supports
29 care system, including transitions among levels of care and between
30 service locations.

31 (D) Develop individual care plans for higher risk beneficiaries
32 based on the results of the risk assessment process with a particular
33 focus on long-term services and supports.

34 (E) Use nurses, social workers, the beneficiary's primary care
35 physician, if appropriate, and other medical professionals to provide
36 care management and enhanced care management, as applicable,
37 particularly for beneficiaries in need of or receiving long-term
38 services and supports.

39 (F) Consider behavioral health needs of beneficiaries and
40 coordinate those services with the county mental health department

1 as part of the beneficiary’s care management plan when
2 appropriate.

3 (G) Facilitate a beneficiary’s ability to access appropriate
4 community resources and other agencies, including referrals as
5 necessary and appropriate for behavioral services, such as mental
6 health and substance use disorders treatment services.

7 (H) Monitor skilled nursing facility utilization and develop care
8 transition plans and programs that move beneficiaries back into
9 the community to the extent possible. Plans shall monitor and
10 support beneficiaries in the community to avoid further
11 institutionalization.

12 (5) Ensure that the managed care health plans comply with, at
13 a minimum, and in addition to other statutory and contractual
14 requirements, network adequacy requirements as follows:

15 (A) Provide access to providers that comply with applicable
16 state and federal law, including, but not limited to, physical
17 accessibility and the provision of health plan information in
18 alternative formats.

19 (B) Meet provider network adequacy standards for long-term
20 services and supports that the department shall develop.

21 (C) Maintain an updated, accurate, and accessible listing of a
22 provider’s ability to accept new patients, which shall be made
23 available to beneficiaries, at a minimum, by phone, written
24 material, and the Internet, and in accessible formats, upon request.

25 (D) Monitor an appropriate provider network that includes an
26 adequate number of accessible facilities within each service area.

27 (E) Contract with and assign patients to safety net and traditional
28 providers as defined in subdivisions (hh) and (jj), respectively, of
29 Section 53810 of Title 22 of the California Code of Regulations,
30 including small and private practice providers who have
31 traditionally treated dual eligible patients, based on available
32 medical history to ensure access to care and services. A managed
33 care health plan shall establish participation standards to ensure
34 participation and broad representation of traditional and safety net
35 providers within a service area.

36 (F) Maintain a liaison to coordinate with each regional center
37 operating within the plan’s service area to assist dual eligible
38 beneficiaries with developmental disabilities in understanding and
39 accessing services and act as a central point of contact for
40 questions, access and care concerns, and problem resolution.

1 (G) Maintain a liaison and provide access to out-of-network
2 providers, for up to 12 months, for new members enrolled under
3 Sections 14132.275 and 14182.16 who have an ongoing
4 relationship with a provider, if the provider will accept the health
5 plan's rate for the service offered, or for nursing facilities and
6 Community-Based Adult Services, or the applicable Medi-Cal
7 fee-for-service rate, whichever is higher, and the managed care
8 health plan determines that the provider meets applicable
9 professional standards and has no disqualifying quality of care
10 issues in accordance with guidance from the department, including
11 all-plan letters. A partial-benefit dual eligible beneficiary enrolled
12 in Medicare Part A who only receives primary and specialty care
13 services through a Medi-Cal managed care health plan shall be
14 able to receive these Medi-Cal services from an out-of-network
15 Medi-Cal provider for 12 months after enrollment. This
16 subparagraph shall not apply to out-of-network providers that
17 furnish ancillary services.

18 (H) Assign a primary care physician who is the primary clinician
19 for the beneficiary and who provides core clinical management
20 functions for partial-benefit dual eligible beneficiaries who are
21 receiving primary and specialty care through the Medi-Cal
22 managed care health plan.

23 (I) Employ care managers directly or contract with nonprofit
24 or proprietary organizations in sufficient numbers to provide
25 coordinated care services for long-term services and supports as
26 needed for all members.

27 (6) Ensure that the managed care health plans address medical
28 and social needs as follows:

29 (A) Offer services beyond those required by Medicare and
30 Medi-Cal at the managed care health plan's discretion.

31 (B) Refer beneficiaries to community resources or other agencies
32 for needed medical or social services or items outside the managed
33 care health plan's responsibilities.

34 (C) Facilitate communication among a beneficiary's health care
35 and personal care providers, including long-term services and
36 supports and behavioral health providers when appropriate.

37 (D) Engage in other activities or services needed to assist
38 beneficiaries in optimizing their health status, including assisting
39 with self-management skills or techniques, health education, and
40 other modalities to improve health status.

1 (E) Facilitate timely access to primary care, specialty care,
2 medications, and other health services needed by the beneficiary,
3 including referrals to address any physical or cognitive barriers to
4 access.

5 (F) Utilize the most recent common procedure terminology
6 (CPT) codes, modifiers, and correct coding initiative edits.

7 (7) (A) Ensure that the managed care health plans provide, at
8 a minimum, and in addition to other statutory and contractual
9 requirements, a grievance and appeal process that does both of the
10 following:

11 (i) Provides a clear, timely, and fair process for accepting and
12 acting upon complaints, grievances, and disenrollment requests,
13 including procedures for appealing decisions regarding coverage
14 or benefits, as specified by the department. Each managed care
15 health plan shall have a grievance process that complies with
16 Section 14450, and Sections 1368 and 1368.01 of the Health and
17 Safety Code.

18 (ii) Complies with a Medicare and Medi-Cal grievance and
19 appeal process, as applicable. The appeals process shall not
20 diminish the grievance and appeals rights of IHSS recipients
21 pursuant to Section 10950.

22 (B) In no circumstance shall the process for appeals be more
23 restrictive than what is required under the Medi-Cal program.

24 (e) The department shall do all of the following:

25 (1) Monitor the managed care health plans' performance and
26 accountability for provision of services, in addition to all other
27 statutory and contractual monitoring and oversight requirements,
28 by doing all of the following:

29 (A) Develop performance measures that are required as part of
30 the contract to provide quality indicators for the Medi-Cal
31 population enrolled in a managed care health plan and for the dual
32 eligible subset of enrollees. These performance measures may
33 include measures from the Healthcare Effectiveness Data and
34 Information Set or measures indicative of performance in serving
35 special needs populations, such as the National Committee for
36 Quality Assurance structure and process measures, or other
37 performance measures identified or developed by the department.

38 (B) Implement performance measures that are required as part
39 of the contract to provide quality assurance indicators for long-term
40 services and supports in quality assurance plans required under

1 the plans' contracts. These indicators shall include factors such as
2 affirmative member choice, increased independence, avoidance
3 of institutional care, and positive health outcomes. The department
4 shall develop these quality assurance indicators in consultation
5 with stakeholder groups.

6 (C) Effective January 10, 2014, and for each subsequent year
7 of the demonstration project authorized under Section 14132.275,
8 provide a report to the Legislature describing the degree to which
9 Medi-Cal managed care health plans in counties participating in
10 the demonstration project have fulfilled the quality requirements,
11 as set forth in the health plan contracts.

12 (D) Effective June 1, 2014, and for each subsequent year of the
13 demonstration project authorized by Section 14132.275, provide
14 a joint report, from the department and from the Department of
15 Managed Health Care, to the Legislature summarizing information
16 from both of the following:

17 (i) The independent audit report required to be submitted
18 annually to the Department of Managed Health Care by managed
19 care health plans participating in the demonstration project
20 authorized by Section 14132.275.

21 (ii) Any routine financial examinations of managed care health
22 plans operating in the demonstration project authorized by Section
23 14132.275 that have been conducted and completed for the
24 previous calendar year by the Department of Managed Health Care
25 and the department.

26 (2) Monitor on a quarterly basis the utilization of covered
27 services of beneficiaries enrolled in the demonstration project
28 pursuant to Section 14132.275 or receiving long-term services and
29 supports pursuant to Article 5.7 (commencing with Section 14186).

30 (3) Develop requirements for managed care health plans to
31 solicit stakeholder and member participation in advisory groups
32 for the planning and development activities relating to the provision
33 of services for dual eligible beneficiaries.

34 (4) Submit to the Legislature the following information:

35 (A) Provide, to the fiscal and appropriate policy committees of
36 the Legislature, a copy of any report submitted to CMS pursuant
37 to the approved federal waiver described in Section 14180.

38 (B) Together with the State Department of Social Services, the
39 California Department of Aging, and the Department of Managed
40 Health Care, in consultation with stakeholders, develop a

1 programmatic transition plan, and submit that plan to the
2 Legislature within 90 days of the effective date of this section. The
3 plan shall include, but is not limited to, the following components:

4 (i) A description of how access and quality of service shall be
5 maintained during and immediately after implementation of these
6 provisions, in order to prevent unnecessary disruption of services
7 to beneficiaries.

8 (ii) Explanations of the operational steps, timelines, and key
9 milestones for determining when and how the components of
10 paragraphs (1) to (9), inclusive, shall be implemented.

11 (iii) The process for addressing consumer complaints, including
12 the roles and responsibilities of the departments and health plans
13 and how those roles and responsibilities shall be coordinated. The
14 process shall outline required response times and the method for
15 tracking the disposition of complaint cases. The process shall
16 include the use of an ombudsman, liaison, and 24-hour hotline
17 dedicated to assisting Medi-Cal beneficiaries navigate among the
18 departments and health plans to help ensure timely resolution of
19 complaints.

20 (iv) A description of how stakeholders were included in the
21 various phases of the planning process to formulate the transition
22 plan, and how their feedback shall be taken into consideration after
23 transition activities begin.

24 (C) The department, together with the State Department of
25 Social Services, the California Department of Aging, and the
26 Department of Managed Health Care, convene and consult with
27 stakeholders at least twice during the period following production
28 of a draft of the implementation plan and before submission of the
29 plan to the Legislature. Continued consultation with stakeholders
30 shall occur on an ongoing basis for the implementation of the
31 provisions of this section.

32 (D) No later than 90 days prior to the initial plan enrollment
33 date of the demonstration project pursuant to the provisions of
34 Sections 14132.275, 14182.16, and of Article 5.7 (commencing
35 with Section 14186), assess and report to the fiscal and appropriate
36 policy committees of the Legislature on the readiness of the
37 managed care health plans to address the unique needs of dual
38 eligible beneficiaries and Medi-Cal only seniors and persons with
39 disabilities pursuant to the applicable readiness evaluation criteria
40 and requirements set forth in paragraphs (1) to (8), inclusive, of

1 subdivision (b) of Section 14087.48. The report shall also include
2 an assessment of the readiness of the managed care health plans
3 in each county participating in the demonstration project to have
4 met the requirements set forth in paragraphs (1) to (9), inclusive.

5 (E) The department shall submit two reports to the Legislature,
6 with the first report submitted five months prior to the
7 commencement date of enrollment and the second report submitted
8 three months prior to the commencement date of enrollment, that
9 describe the status of all of the following readiness criteria and
10 activities that the department shall complete:

11 (i) Enter into contracts, either directly or by funding other
12 agencies or community-based, nonprofit, consumer, or health
13 insurance assistance organizations with expertise and experience
14 in providing health plan counseling or other direct health consumer
15 assistance to dual eligible beneficiaries, in order to assist these
16 beneficiaries in understanding their options to participate in the
17 demonstration project specified in Section 14132.275 and to
18 exercise their rights and address barriers regarding access to
19 benefits and services.

20 (ii) Develop a plan to ensure timely and appropriate
21 communications with beneficiaries as follows:

22 (I) Develop a plan to inform beneficiaries of their enrollment
23 options and rights, including specific steps to work with consumer
24 and beneficiary community groups described in clause (i),
25 consistent with the provisions of paragraph (1).

26 (II) Design, in consultation with consumers, beneficiaries, and
27 stakeholders, all enrollment-related notices, including, but not
28 limited to, summary of benefits, evidence of coverage, prescription
29 formulary, and provider directory notices, as well as all appeals
30 and grievance-related procedures and notices produced in
31 coordination with existing federal Centers for Medicare and
32 Medicaid Services (CMS) guidelines.

33 (III) Design a comprehensive plan for beneficiary and provider
34 outreach, including specific materials for persons in nursing and
35 group homes, family members, conservators, and authorized
36 representatives of beneficiaries, as appropriate, and providers of
37 services and supports.

38 (IV) Develop a description of the benefits package available to
39 beneficiaries in order to assist them in plan selection and how they

1 may select and access services in the demonstration project's
2 assessment and care planning process.

3 (V) Design uniform and plain language materials and a process
4 to inform seniors and persons with disabilities of copays and
5 covered services so that beneficiaries can make informed choices.

6 (VI) Develop a description of the process, except in those
7 demonstration counties that have a county operated health system,
8 of automatically assigning beneficiaries into managed care health
9 plans that shall include a requirement to consider Medicare service
10 utilization, provider data, and consideration of plan quality.

11 (iii) Finalize rates and comprehensive contracts between the
12 department and participating health plans to facilitate effective
13 outreach, enroll network providers, and establish benefit packages.
14 To the extent permitted by CMS, the plan rates and contract
15 structure shall be provided to the appropriate fiscal and policy
16 committees of the Legislature and posted on the department's
17 Internet Web site so that they are readily available to the public.

18 (iv) Ensure that contracts have been entered into between plans
19 and providers including, but not limited to, agreements with county
20 agencies as necessary.

21 (v) Develop network adequacy standards for medical care and
22 long-term supports and services that reflect the provisions of
23 paragraph (5).

24 (vi) Identify dedicated department or contractor staff with
25 adequate training and availability during business hours to address
26 and resolve issues between health plans and beneficiaries, and
27 establish a requirement that health plans have similar points of
28 contact and are required to respond to state inquiries when
29 continuity of care issues arise.

30 (vii) Develop a tracking mechanism for inquiries and complaints
31 for quality assessment purposes, and post publicly on the
32 department's Internet Web site information on the types of issues
33 that arise and data on the resolution of complaints.

34 (viii) Prepare scripts and training for the department and plan
35 customer service representatives on all aspects of the program,
36 including training for enrollment brokers and community-based
37 organizations on rules of enrollment and counseling of
38 beneficiaries.

39 (ix) Develop continuity of care procedures.

1 (x) Adopt quality measures to be used to evaluate the
2 demonstration projects. Quality measures shall be detailed enough
3 to enable measurement of the impact of automatic plan assignment
4 on quality of care.

5 (xi) Develop reporting requirements for the plans to report to
6 the department, including data on enrollments and disenrollments,
7 appeals and grievances, and information necessary to evaluate
8 quality measures and care coordination models. The department
9 shall report this information to the appropriate fiscal and policy
10 committees of the Legislature, and this information shall be posted
11 on the department's Internet Web site.

12 (f) This section shall be implemented only to the extent that all
13 federal approvals and waivers are obtained and only if and to the
14 extent that federal financial participation is available.

15 (g) To implement this section, the department may contract with
16 public or private entities. Contracts or amendments entered into
17 under this section may be on an exclusive or nonexclusive basis
18 and a noncompetitive bid basis and shall be exempt from the
19 following:

20 (1) Part 2 (commencing with Section 10100) of Division 2 of
21 the Public Contract Code and any policies, procedures, or
22 regulations authorized by that part.

23 (2) Article 4 (commencing with Section 19130) of Chapter 5
24 of Part 2 of Division 5 of Title 2 of the Government Code.

25 (3) Review or approval of contracts by the Department of
26 General Services.

27 (h) Notwithstanding Chapter 3.5 (commencing with Section
28 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
29 the department may implement, interpret, or make specific this
30 section and any applicable federal waivers and state plan
31 amendments by means of all-county letters, plan letters, plan or
32 provider bulletins, or similar instructions, without taking regulatory
33 action. Prior to issuing any letter or similar instrument authorized
34 pursuant to this section, the department shall notify and consult
35 with stakeholders, including advocates, providers, and
36 beneficiaries. The department shall notify the appropriate policy
37 and fiscal committees of the Legislature of its intent to issue
38 instructions under this section at least five days in advance of the
39 issuance.

1 SEC. 18. Section 14182.18 is added to the Welfare and
2 Institutions Code, to read:

3 14182.18. (a) It is the intent of the Legislature that both the
4 managed care plans participating in and providing long-term
5 services and supports under Sections 14182.16 and 14186.2 and
6 the state have protections against either significant overpayment
7 or significant underpayments. Risk corridors are one method of
8 risk sharing that may limit the financial risk of misaligning the
9 payments associated with a contract to furnish long-term services
10 and supports pursuant to a contract under the Coordinated Care
11 Initiative on an at-risk basis.

12 (b) In Coordinated Care Initiative counties, as defined in
13 paragraph (1) of subdivision (b) of Section 14182.16, for managed
14 care health plans providing long-term services and supports, the
15 department shall include in its contract with those plans risk
16 corridors designed with the following parameters:

17 (1) Risk corridors shall apply only to the costs of the individuals
18 and services identified below:

19 (A) Health care service costs for full benefit dual eligible
20 beneficiaries as defined in paragraph (3) of subdivision (b) of
21 Section 14182.16 for whom both of the following are true:

22 (i) The beneficiary is enrolled in the managed care health plan
23 and the plan's contract covers all Medi-Cal long-term services
24 and supports.

25 (ii) The beneficiary is not enrolled in the demonstration project.

26 (B) Long-term services and supports costs for partial benefit
27 dual eligible beneficiaries as defined in paragraph (7) of
28 subdivision (b) of Section 14182 and non-dual-eligible
29 beneficiaries who are enrolled in the managed care health plan
30 and the plan's contract covers all Medi-Cal long-term services
31 and supports.

32 (2) Risk corridors applied to costs of beneficiary services
33 identified in subparagraph (A) of paragraph (1) shall only be in
34 place for a period of 24 months starting with the first month in
35 which both mandatory enrollment of full benefit dual eligible
36 beneficiaries pursuant to Section 14182.16 and mandatory
37 coverage of all Medi-Cal long-term services and supports pursuant
38 to Section 14186.2 have occurred.

39 (3) Risk corridors applied to costs of beneficiary services
40 identified in subparagraph (B) of paragraph (1) shall only be in

1 *place for a period of 24 months starting with the first month in*
2 *which mandatory coverage of all Medi-Cal long-term services and*
3 *supports pursuant to Section 14186.2 has occurred.*

4 *(4) The risk sharing of the costs of the individuals and services*
5 *under this subdivision shall be constructed by the department so*
6 *that it is symmetrical with respect to risk and profit, and so that*
7 *all of the following apply:*

8 *(A) The managed care health plan is fully responsible for all*
9 *costs in excess of the capitated rate of the plan up to 1 percent.*

10 *(B) The managed care health plan shall fully retain the revenues*
11 *paid through the capitated rate in excess of the costs incurred up*
12 *to 1 percent.*

13 *(C) The managed care health plan and the department shall*
14 *share responsibility for costs in excess of the capitated rate of the*
15 *plan that are greater than 1 percent above the rate but less than*
16 *2.5 percent above the rate.*

17 *(D) The managed care health plan and the department shall*
18 *share the benefit of revenues in excess of the costs incurred that*
19 *are greater than 1 percent below the capitated rate of the plan but*
20 *less than 2.5 percent below the capitated rate of the plan.*

21 *(E) The department shall be fully responsible for all costs in*
22 *excess of the capitated rate of the plan that are more than 2.5*
23 *percent above the capitated rate of the plan.*

24 *(F) The department shall fully retain the revenues paid through*
25 *the capitated rate in excess of the costs incurred greater than 2.5*
26 *percent below the capitated rate of the plan.*

27 *(c) The department shall develop specific contractual language*
28 *implementing the requirements of this section and corresponding*
29 *details that shall be incorporated into the managed care health*
30 *plan's contract.*

31 *(d) This section shall be implemented only to the extent that any*
32 *necessary federal approvals or waivers are obtained.*

33 *SEC. 19. Section 14183.6 of the Welfare and Institutions Code*
34 *is amended to read:*

35 *14183.6. (a) The department shall enter into an interagency*
36 *agreement with the Department of Managed Health Care to have*
37 *the Department of Managed Health Care, on behalf of the*
38 *department, conduct financial audits, medical surveys, and a review*
39 *of the provider networks of the managed care health plans*
40 *participating in the demonstration project and the Medi-Cal*

1 managed care expansion into rural counties, and to provide
2 consumer assistance to beneficiaries affected by the provisions of
3 Sections 14182.16 and 14182.17. The interagency agreement shall
4 be updated, as necessary, on an annual basis in order to maintain
5 functional clarity regarding the roles and responsibilities of these
6 core activities. The department shall not delegate its authority
7 under this division as the single state Medicaid agency to the
8 Department of Managed Health Care.

9 *(b) This section shall be inoperative if the Coordinated Care
10 Initiative becomes inoperative pursuant to Section 34 of the act
11 that added this subdivision.*

12 *SEC. 20. Section 14183.6 is added to the Welfare and
13 Institutions Code, to read:*

14 *14183.6. (a) The department shall enter into an interagency
15 agreement with the Department of Managed Health Care to have
16 the Department of Managed Health Care, on behalf of the
17 department, conduct financial audits, medical surveys, and a
18 review of the provider networks of the managed care health plans
19 participating in the demonstration project and the Medi-Cal
20 managed care expansion into rural counties. The interagency
21 agreement shall be updated, as necessary, on an annual basis in
22 order to maintain functional clarity regarding the roles and
23 responsibilities of these core activities. The department shall not
24 delegate its authority under this division as the single state
25 Medicaid agency to the Department of Managed Health Care.*

26 *(b) This section shall be operative only if Section 19 of the act
27 that added this section becomes inoperative pursuant to subdivision
28 (b) of that Section 19.*

29 *SEC. 21. Section 14186 of the Welfare and Institutions Code
30 is amended to read:*

31 *14186. (a) It is the intent of the Legislature that long-term
32 services and supports (LTSS) be covered through managed care
33 health plans in ~~counties participating in the demonstration project~~
34 ~~authorized under Section 14132.275~~ *Coordinated Care Initiative*
35 *counties.**

36 *(b) It is further the intent of the Legislature that all of the
37 following occur:*

38 *(1) Persons receiving health care services through Medi-Cal
39 receive these services through a coordinated health care system*

1 that reduces the unnecessary use of emergency and hospital
2 services.

3 (2) Coordinated health care services, including medical,
4 long-term services and supports, and enhanced care management
5 be covered through Medi-Cal managed care health plans in order
6 to eliminate system inefficiencies and align incentives with positive
7 health care outcomes.

8 (3) Managed care health plans shall, in coordination with LTSS
9 care management providers, develop and expand care coordination
10 practices in consultation with counties, nursing facilities, area
11 agencies on aging, and other home- and community-based
12 providers, and share best practices. Unless the consumer objects,
13 managed care health plans may establish care coordination teams
14 as needed. If the consumer is an IHSS recipient, his or her
15 participation and the participation of his or her provider shall be
16 subject to the consumer's consent. These care coordination teams
17 shall include the consumer, and his or her authorized representative,
18 health plan, county social services agency, Community-Based
19 Adult Services (CBAS) case manager for CBAS clients,
20 Multipurpose Senior Services Program (MSSP) case manager for
21 MSSP clients, and, if an IHSS recipient, may include others.

22 (4) To the extent possible, for Medi-Cal beneficiaries also
23 enrolled in the Medicare Program, that the department work with
24 the federal government to coordinate financing and incentives and
25 permit managed care health plans to coordinate health care
26 provided under both health care systems.

27 (5) The health care choices made by Medi-Cal beneficiaries be
28 considered with regard to all of the following:

29 (A) Receiving care in a home- and community-based setting to
30 maintain independence and quality of life.

31 (B) Selecting their health care providers in the managed care
32 plan network.

33 (C) Controlling care planning, decisionmaking, and coordination
34 with their health care providers.

35 (D) Gaining access to services that are culturally, linguistically,
36 and operationally sensitive to meet their needs or limitations and
37 that improve their health outcomes, enhance independence, and
38 promote living in home- and community-based settings.

39 (E) Self-directing their care by being able to hire, fire, and
40 supervise their IHSS provider.

1 (F) Being assured by the department and coordinating
2 departments of their oversight of the quality of these coordinated
3 health care services.

4 (6) (A) Counties continue to perform functions necessary for
5 the administration of the IHSS program, including conducting
6 assessments and determining authorized hours for recipients,
7 pursuant to Article 7 (commencing with Section 12300) of Chapter
8 3. County agency assessments shall be shared with care
9 coordination teams, when applicable. The county agency thereafter
10 may receive and consider additional input from the care
11 coordination team.

12 (B) Managed care health plans may authorize personal care
13 services and related domestic services in addition to the hours
14 authorized under Article 7 (commencing with Section 12300) of
15 Chapter 3, which managed care health plans shall be responsible
16 for paying at no share of cost to the county. The department, in
17 consultation with the State Department of Social Services, shall
18 develop policies and procedures for these additional benefits, which
19 managed care health plans may authorize. The grievance process
20 for these benefits shall be the same process as used for other
21 benefits authorized by managed care health plans, and shall comply
22 with Section 14450, and Sections 1368 and 1368.1 of the Health
23 and Safety Code.

24 (7) (A) Effective January 1, 2015, or 19 months after
25 commencement of beneficiary enrollment ~~in the demonstration~~
26 ~~project authorized pursuant to Section 14132.275 into managed~~
27 ~~care pursuant to Sections 14182 and 14182.16~~, whichever is later,
28 MSSP services shall transition from a federal waiver pursuant to
29 Section 1915(c) under the federal Social Security Act (42 U.S.C.
30 Sec. 1396n et seq.) to a benefit administered and allocated by
31 managed care health plans *in Coordinated Care Initiative counties*.

32 ~~It~~

33 (B) *Notwithstanding Chapter 8 (commencing with Section 9560)*
34 *of Division 8.5, it is also the intent of the Legislature that the*
35 *provisions of this article and the demonstration project pursuant*
36 *to Section 14132.275 shall apply to dual eligible and Medi-Cal-only*
37 *beneficiaries enrolled in MSSP. It is the further intent of the*
38 *Legislature that managed care health plans shall work in*
39 *collaboration with MSSP providers to begin development of an*
40 *integrated, person-centered care management and care coordination*

1 model that works within the context of managed care, and explore
2 which portions of the MSSP program model may be adapted to
3 managed care while maintaining the integrity and efficacy of the
4 MSSP model.

5 (8) In lieu of providing nursing facility services, managed care
6 health plans may authorize home- and community-based services
7 plan benefits, as defined in subdivision ~~(e)~~ (d) of Section 14186.1,
8 which managed care health plans shall be responsible for paying
9 at no share of cost to the county.

10 *SEC. 22. Section 14186.1 of the Welfare and Institutions Code*
11 *is amended to read:*

12 14186.1. For purposes of this article, the following definitions
13 shall apply unless otherwise specified:

14 (a) “Coordinated Care Initiative counties” shall have the same
15 meaning as that term is defined in paragraph (1) of subdivision
16 (b) of Section 14182.16.

17 ~~(a)~~

18 (b) “Home- and community-based services” means services
19 provided pursuant to paragraphs (1), (2), and (3) of subdivision
20 ~~(b)~~ (c).

21 ~~(b)~~

22 (c) “Long-term services and supports” or “LTSS” means all of
23 the following:

24 (1) In-home supportive services (IHSS) provided pursuant to
25 Article 7 (commencing with Section 12300) of Chapter 3, and
26 Sections 14132.95, 14132.952, and 14132.956.

27 (2) Community-Based Adult Services (CBAS).

28 (3) Multipurpose Senior Services Program (MSSP) services
29 include those services approved under a federal home- and
30 community-based services waiver or, beginning January 1, 2015,
31 *or after 19 months*, equivalent services.

32 (4) Skilled nursing facility services and subacute care services
33 established under subdivision (c) of Section 14132, including those
34 services described in Sections 51511 and 51511.5 of Title 22 of
35 the California Code of Regulations, regardless of whether the
36 service is included in the basic daily rate or billed separately, and
37 any leave of absence or bed hold provided consistent with Section
38 72520 of Title 22 of the California Code of Regulations or the
39 state plan.

1 However, services provided by any category of intermediate
2 care facility for the developmentally disabled shall not be
3 considered long-term services and supports.

4 (e)

5 (d) “Home- and community-based services (HCBS) plan
6 benefits” may include in-home and out-of-home respite, nutritional
7 assessment, counseling, and supplements, minor home or
8 environmental adaptations, habilitation, and other services that
9 may be deemed necessary by the managed care health plan,
10 including its care coordination team. The department, in
11 consultation with stakeholders, may determine whether health
12 plans shall be required to include these benefits in their scope of
13 service, and may establish guidelines for the scope, duration, and
14 intensity of these benefits. The grievance process for these benefits
15 shall be the same process as used for other benefits authorized by
16 managed care health plans, and shall comply with Section 14450,
17 and Sections 1368 and 1368.1 of the Health and Safety Code.

18 (d)

19 (e) “Managed care health plan” means an individual,
20 organization, or entity that enters into a contract with the
21 department pursuant to Article 2.7 (commencing with Section
22 14087.3), Article 2.8 (commencing with Section 14087.5), Article
23 2.81 (commencing with Section 14087.96), or Article 2.91
24 (commencing with Section 14089), of this chapter, or Chapter 8
25 (commencing with Section 14200). For the purposes of this article,
26 “managed care health plan” shall not include an individual,
27 organization, or entity that enters into a contract with the
28 department to provide services pursuant to Chapter 8.75
29 (commencing with Section 14591) or the Senior Care Action
30 Network.

31 (e)

32 (f) “Other health coverage” means health coverage providing
33 the same full or partial benefits as the Medi-Cal program, health
34 coverage under another state or federal medical care program
35 except for the Medicare Program (Title XVIII of the federal Social
36 Security Act (42 U.S.C. Sec. 1395 et seq.)), or health coverage
37 under a contractual or legal entitlement, including, but not limited
38 to, a private group or indemnification insurance program.

39 (f)

1 (g) “Recipient” means a Medi-Cal beneficiary eligible for IHSS
2 provided pursuant to Article 7 (commencing with Section 12300)
3 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

4 *SEC. 23. Section 14186.11 is added to the Welfare and*
5 *Institutions Code, immediately following Section 14186.1, to read:*

6 *14186.11. Section 14186.17 shall apply to the provision of*
7 *CBAS, MSSP, skilled nursing facility, and IHSS services in*
8 *Coordinated Care Initiative counties as set forth in this article.*

9 *SEC. 24. Section 14186.2 of the Welfare and Institutions Code*
10 *is amended to read:*

11 14186.2. (a) (1) Not sooner than March 1, 2013, all Medi-Cal
12 long-term services and supports (LTSS) described in subdivision
13 ~~(b)~~ (c) of Section 14186.1 shall be services that are covered under
14 managed care health plan contracts and shall be available only
15 through managed care health plans to beneficiaries residing in
16 ~~counties participating in the demonstration project authorized under~~
17 ~~Section 14132.275~~ *Coordinated Care Initiative counties*, except
18 for the exemptions provided for in subdivision (c). The director
19 shall consult with the Legislature, CMS, and stakeholders when
20 determining the implementation date for this section. The
21 department shall pay managed care health plans using a capitation
22 ratesetting methodology that pays for all Medi-Cal benefits and
23 services, including all LTSS, covered under the managed care
24 health plan contract. In order to receive any LTSS through
25 Medi-Cal, Medi-Cal beneficiaries shall mandatorily enroll in a
26 managed care health plan for the provision of Medi-Cal benefits.

27 (2) HCBS plan benefits may be covered services that are
28 provided under managed care health plan contracts for beneficiaries
29 ~~residing in counties participating in the demonstration authorized~~
30 ~~under Section 14132.275~~ *Coordinated Care Initiative counties*,
31 except for the exemptions provided for in subdivision (c).

32 (3) Beneficiaries who are not mandatorily enrolled in a managed
33 care health plan pursuant to paragraph (15) of subdivision (b) of
34 Section 14182 shall not be required to receive LTSS through a
35 managed care health plan.

36 (4) The transition of the provision of LTSS through managed
37 care health plans shall occur after the department obtains any
38 federal approvals through necessary federal waivers or
39 amendments, or state plan amendments.

1 (5) Counties where LTSS are not covered through managed
2 care health plans shall not be subject to this article.

3 (6) Beneficiaries residing in counties not participating in the
4 dual eligible demonstration project pursuant to Section 14132.275
5 shall not be subject to this article.

6 (b) (1) The provisions of this article shall be applicable to a
7 Medi-Cal beneficiary enrolled in a managed care health plan in a
8 county where this article is effective.

9 (2) At the director's sole discretion, in consultation with
10 coordinating departments and stakeholders, the department may
11 determine and implement a phased-in enrollment approach that
12 may include the addition of Medi-Cal long-term services and
13 supports in a beneficiary's Medi-Cal managed care benefits
14 immediately upon implementation of this article in a specific
15 county, over a 12-month period, or other phased approach, but no
16 sooner than March 1, 2013.

17 (c) (1) The provisions of this article shall not apply to any of
18 the following individuals:

19 (A) Medi-Cal beneficiaries who meet any of the following and
20 shall, therefore, continue to receive any medically necessary
21 Medi-Cal benefits, including LTSS, through fee-for-service
22 Medi-Cal:

23 (i) Except in counties with county organized health systems
24 operating pursuant to Article 2.8 (commencing with Section
25 14087.5), have other health coverage.

26 (ii) Receive services through any state foster care program
27 including the program described in Article 5 (commencing with
28 Section 11400) Chapter 2, unless the beneficiary is already
29 receiving services through a managed care health plan.

30 (iii) Are not eligible for enrollment in managed care health plans
31 for medically necessary reasons determined by the department.

32 (iv) Reside in one of the Veterans' Homes of California, as
33 described in Chapter 1 (commencing with Section 1010) of
34 Division 5 of the Military and Veterans Code.

35 (B) Persons enrolled in the Program of All-Inclusive Care for
36 the Elderly (PACE) pursuant to Chapter 8.75 (commencing with
37 Section 14591), or a managed care organization licensed under
38 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
39 2.2 (commencing with Section 1340) of Division 2 of the Health
40 and Safety Code) that has previously contracted with the

1 department as a primary care case management plan pursuant to
2 Article 2.9 (commencing with Section 14088) of Chapter 7 to
3 provide services to beneficiaries who are HIV positive or who
4 have been diagnosed with AIDS.

5 (C) Persons who are under 21 years of age.

6 (D) Other specific categories of beneficiaries specified by the
7 department based on extraordinary medical needs of specific patient
8 groups or to meet federal requirements, in consultation with
9 stakeholders.

10 (2) Beneficiaries who have been diagnosed with HIV/AIDS are
11 not exempt from mandatory enrollment, but may opt out of
12 managed care enrollment at the beginning of any month.

13 (d) *If the LTSS portion of the Coordinated Care Initiative pilot*
14 *is implemented, the provisions of Section 14186.35 shall apply.*

15 *SEC. 25. Section 14186.3 of the Welfare and Institutions Code*
16 *is amended to read:*

17 14186.3. (a) (1) No sooner than July 1, 2012,
18 Community-Based Adult Services (CBAS) shall be a Medi-Cal
19 benefit covered under every managed care health plan contract
20 and available only through managed care health plans. Medi-Cal
21 beneficiaries who are eligible for CBAS shall enroll in a managed
22 care health plan in order to receive those services, except for
23 beneficiaries exempt under subdivision (c) of Section 14186.2 or
24 in counties or geographic regions where Medi-Cal benefits are not
25 covered through managed care health plans. Notwithstanding
26 subdivision (a) of Section 14186.2 and pursuant to the provisions
27 of an approved federal waiver or plan amendment, the provision
28 of CBAS as a Medi-Cal benefit through a managed care health
29 plan shall not be limited to *Coordinated Care Initiative* counties
30 ~~participating in the demonstration project authorized under Section~~
31 ~~14132.275.~~

32 (2) Managed care health plans shall determine a member's
33 medical need for CBAS using the assessment tool and eligibility
34 criteria established pursuant to the provisions of an approved
35 federal waiver or amendments and shall approve the number of
36 days of attendance and monitor treatment plans of their members.
37 Managed care health plans shall reauthorize CBAS in compliance
38 with criteria established pursuant to the provisions of the approved
39 federal waiver or amendment requirements.

1 (b) (1) Beginning in the 2012 calendar year, managed care
2 health plans shall collaborate with MSSP providers to begin
3 development of an integrated, person-centered care management
4 and care coordination model and explore how the MSSP program
5 model may be adapted to managed care while maintaining the
6 efficacy of the MSSP model. The California Department of Aging
7 and the department shall work with the MSSP site association and
8 managed care health plans to develop a template contract to be
9 used by managed care health plans contracting with MSSP sites
10 in counties where the demonstration project pursuant to Section
11 ~~14132.275 is implemented~~ *Coordinated Care Initiative counties*.

12 (2) Notwithstanding the implementation date authorized in
13 paragraph (1) of subdivision (a) of Section 14186.2, beginning no
14 sooner than June 1, 2013, or on the date that any necessary federal
15 approvals or waivers are obtained, whichever is later, and
16 ~~concluding~~ *effective* January 1, 2015, or 19 months after
17 commencement of beneficiary enrollment ~~in the demonstration~~
18 ~~project authorized pursuant to Section 14132.275, or on the date~~
19 ~~that any necessary federal approvals or waivers are obtained into~~
20 *managed care pursuant to Sections 14182 and 14182.16*, whichever
21 is later:

22 (A) Multipurpose Senior Services Program (MSSP) services
23 shall be a Medi-Cal benefit available only through managed care
24 health plans, except for beneficiaries exempt under subdivision
25 (c) of Section 14186.2 *in Coordinated Care Initiative counties*.

26 (B) Managed care health plans shall contract with all county
27 and nonprofit organizations that are designated providers of MSSP
28 services for the provision of MSSP case management and waiver
29 services. These contracts shall provide for all of the following:

30 (i) Managed care health plans shall allocate to the MSSP
31 providers the same level of funding they would have otherwise
32 received under their MSSP contract with the California Department
33 of Aging.

34 (ii) MSSP providers shall continue to meet all existing federal
35 waiver standards and program requirements, which include
36 maintaining the contracted service levels.

37 (iii) Managed care plans and MSSP providers shall share
38 confidential beneficiary data with one another, as necessary to
39 implement the provisions of this section.

1 (C) The California Department of Aging shall continue to
2 contract with all designated MSSP sites, including those in the
3 counties participating in the demonstration project, and perform
4 MSSP waiver oversight and monitoring.

5 (D) The California Department of Aging and the department,
6 in consultation with MSSP providers, managed care health plans,
7 and stakeholders, shall develop service fee structures, services,
8 and person-centered care coordination models that shall be effective
9 June 2013, for the provision of care coordination and home- and
10 community-based services to beneficiaries who are enrolled in
11 managed care health plans but not enrolled in MSSP, and who
12 may have care coordination and service needs that are similar to
13 MSSP participants. The service fees for MSSP providers and MSSP
14 services for any additional beneficiaries and additional services
15 for existing MSSP beneficiaries shall be based upon, and consistent
16 with, the rates and services delivered in MSSP.

17 (3) In the 2014 calendar year, the provisions of paragraph (2)
18 shall continue. In addition, managed care health plans shall work
19 in collaboration with MSSP providers to begin development of an
20 integrated, person-centered care management and care coordination
21 model that works within the context of managed care and explore
22 which portions of the MSSP program model may be adapted to
23 managed care while maintaining the integrity and efficacy of the
24 MSSP model.

25 (4) (A) Effective January 1, 2015, or 19 months after the
26 commencement of beneficiary enrollment ~~in the demonstration~~
27 ~~project authorized pursuant to Section 14132.275 into managed~~
28 ~~care pursuant to Sections 14182 and 14182.16~~, or on the date that
29 any necessary federal approvals or waivers are obtained, whichever
30 is later, MSSP services in ~~counties where the demonstration project~~
31 ~~authorized under Section 14132.275 is implemented~~ *Coordinated*
32 *Care Initiative counties* shall transition from a federal waiver
33 pursuant to Section 1915(c) under the federal Social Security Act
34 (42 U.S.C. Sec. 1396n et seq.) to a benefit administered and
35 allocated by managed care health plans.

36 (B) No later than January 1, 2014, the department, in
37 consultation with the California Department of Aging and the
38 Department of Managed Health Care, and with stakeholder input,
39 shall submit a transition plan to the Legislature to describe how
40 subparagraph (A) shall be implemented. The plan shall incorporate

1 the principles of the MSSP in the managed care benefit, and shall
2 include provisions to ensure seamless transitions and continuity
3 of care. Managed care health plans shall, in partnership with local
4 MSSP providers, conduct a local stakeholder process to develop
5 recommendations that the department shall consider when
6 developing the transition plan.

7 (C) No later than 90 days prior to implementation of
8 subparagraph (A), the department, in consultation with the
9 California Department of Aging and the Department of Managed
10 Health Care, and with stakeholder input, shall submit a transition
11 plan to the Legislature that includes steps to address concerns, if
12 any, raised by stakeholders subsequent to the plan developed
13 pursuant to subparagraph (B).

14 (c) (1) Not sooner than March 1, 2013, or on the date that any
15 necessary federal approvals or waivers are obtained, whichever is
16 later, nursing facility services and subacute facility services shall
17 be Medi-Cal benefits available only through managed care health
18 plans.

19 (2) Managed care health plans shall authorize utilization of
20 nursing facility services or subacute facility services for their
21 members when medically necessary. The managed care health
22 plan shall maintain the standards for determining levels of care
23 and authorization of services for both Medicare and Medi-Cal
24 services that are consistent with policies established by the federal
25 Centers for Medicare and Medicaid Services and consistent with
26 the criteria for authorization of Medi-Cal services specified in
27 Section 51003 of Title 22 of the California Code of Regulations,
28 which includes utilization of the “Manual of Criteria for Medi-Cal
29 Authorization,” published by the department in January 1982, last
30 revised April 11, 2011.

31 (3) The managed care health plan shall maintain continuity of
32 care for beneficiaries by recognizing any prior treatment
33 authorization made by the department for not less than six months
34 following enrollment of a beneficiary into the health plan.

35 (4) When a managed care health plan has authorized services
36 in a facility and there is a change in the beneficiary’s condition
37 under which the facility determines that the facility may no longer
38 meet the needs of the beneficiary, the beneficiary’s health has
39 improved sufficiently so the resident no longer needs the services
40 provided by the facility, or the health or safety of individuals in

1 the facility is endangered by the beneficiary, the managed care
2 health plan shall arrange and coordinate a discharge of the
3 beneficiary and continue to pay the facility the applicable rate until
4 the beneficiary is successfully discharged and transitioned into an
5 appropriate setting.

6 (5) The managed care health plan shall pay providers, including
7 institutional providers, in accordance with the prompt payment
8 provisions contained in each health plan's contracts with the
9 department, including the ability to accept and pay electronic
10 claims.

11 *SEC. 26. Section 14186.36 of the Welfare and Institutions Code*
12 *is amended to read:*

13 14186.36. (a) It is the intent of the Legislature that a universal
14 assessment process for LTSS be developed and tested. The initial
15 uses of this tool may inform future decisions about whether to
16 amend existing law regarding the assessment processes that
17 currently apply to LTSS programs, including IHSS.

18 (b) (1) In addition to the activities set forth in paragraph (9) of
19 subdivision (a) of Section 14186.35, county agencies shall continue
20 IHSS assessment and authorization processes, including making
21 final determinations of IHSS hours pursuant to Article 7
22 (commencing with Section 12300) of Chapter 3 and regulations
23 promulgated by the State Department of Social Services.

24 (2) No sooner than January 1, 2015, for the counties and
25 beneficiary categories specified in subdivision (e), counties shall
26 also utilize the universal assessment tool, as described in
27 subdivision (c), if one is available and upon completion of the
28 stakeholder process, system design and testing, and county training
29 described in subdivisions (c) and (e), for the provision of IHSS
30 services. This paragraph shall only apply to beneficiaries who
31 consent to the use of the universal assessment process. The
32 managed care health plans shall be required to cover IHSS services
33 based on the results of the universal assessment process specified
34 in this section.

35 (c) (1) No later than June 1, 2013, the department, the State
36 Department of Social Services, and the California Department of
37 Aging shall establish a stakeholder workgroup to develop the
38 universal assessment process, including a universal assessment
39 tool, for home- and community-based services, as defined in
40 subdivision ~~(a)~~ (b) of Section 14186.1. The stakeholder workgroup

1 shall include, but not be limited to, consumers of IHSS and other
2 home- and community-based services and their authorized
3 representatives, managed care health plans, counties, IHSS, MSSP,
4 and CBAS providers, and legislative staff. The universal
5 assessment process shall be used for all home- and
6 community-based services, including IHSS. In developing the
7 process, the workgroup shall build upon the IHSS uniform
8 assessment process and hourly task guidelines, the MSSP
9 assessment process, and other appropriate home- and
10 community-based assessment tools.

11 (2) (A) In developing the universal assessment process, the
12 departments described in paragraph (1) shall develop a universal
13 assessment tool that will inform the universal assessment process
14 and facilitate the development of plans of care based on the
15 individual needs of the consumer. The workgroup shall consider
16 issues including, but not limited to, the following:

17 (i) The roles and responsibilities of the health plans, counties,
18 and home- and community-based services providers administering
19 the assessment.

20 (ii) The criteria for reassessment.

21 (iii) How the results of new assessments would be used for the
22 oversight and quality monitoring of home- and community-based
23 services providers.

24 (iv) How the appeals process would be affected by the
25 assessment.

26 (v) The ability to automate and exchange data and information
27 between home- and community-based services providers.

28 (vi) How the universal assessment process would incorporate
29 person-centered principles and protections.

30 (vii) How the universal assessment process would meet the
31 legislative intent of this article and the goals of the demonstration
32 project pursuant to Section 14132.275.

33 (viii) The qualifications for, and how to provide guidance to,
34 the individuals conducting the assessments.

35 (B) The workgroup shall also consider how this assessment may
36 be used to assess the need for nursing facility care and divert
37 individuals from nursing facility care to home- and
38 community-based services.

39 (d) No later than March 1, 2014, the department, the State
40 Department of Social Services, and the California Department of

1 Aging shall report to the Legislature on the stakeholder
2 workgroup’s progress in developing the universal assessment
3 process, and shall identify the counties and beneficiary categories
4 for which the universal assessment process may be implemented
5 pursuant to subdivision (e).

6 (e) (1) No sooner than January 1, 2015, upon completion of the
7 design and development of a new universal assessment tool,
8 managed care health plans, counties, and other home- and
9 community-based services providers may test the use of the tool
10 for a specific and limited number of beneficiaries who receive or
11 are potentially eligible to receive home- and community-based
12 services pursuant to this article in no fewer than two, and no more
13 than four, of the counties where the provisions of this article are
14 implemented, if the following conditions have been met:

15 (A) The department has obtained any federal approvals through
16 necessary federal waivers or amendments, or state plan
17 amendments, whichever is later.

18 (B) The system used to calculate the results of the tool has been
19 tested.

20 (C) Any entity responsible for using the tool has been trained
21 in its usage.

22 (2) To the extent the universal assessment tool or universal
23 assessment process results in changes to the authorization process
24 and provision of IHSS services, those changes shall be automated
25 in the Case Management Information and Payroll System.

26 (3) The department shall develop materials to inform consumers
27 of the option to participate in the universal assessment tool testing
28 phase pursuant to this paragraph.

29 (f) The department, the State Department of Social Services,
30 and the California Department of Aging shall implement a
31 rapid-cycle quality improvement system to monitor the
32 implementation of the universal assessment process, identify
33 significant changes in assessment results, and make modifications
34 to the universal assessment process to more closely meet the
35 legislative intent of this article and the goals of the demonstration
36 project pursuant to Section 14132.275.

37 (g) Until existing law relating to the IHSS assessment process
38 pursuant to Article 7 (commencing with Section 12300) of Chapter
39 3 is amended, beneficiaries shall have the option to request an
40 additional assessment using the previous assessment process for

1 those home- and community-based services and to receive services
2 according to the results of the additional assessment.

3 (h) No later than nine months after the implementation of the
4 universal assessment process, the department, the State Department
5 of Social Services, and the California Department of Aging, in
6 consultation with stakeholders, shall report to the Legislature on
7 the results of the initial use of the universal assessment process,
8 and may identify proposed additional beneficiary categories or
9 counties for expanded use of this process and any necessary
10 changes to provide statutory authority for the continued use of the
11 universal assessment process. These departments shall report
12 annually thereafter to the Legislature on the status and results of
13 the universal assessment process.

14 (i) ~~The provisions of this~~ This section shall remain operative
15 until July 1, 2017.

16 *SEC. 27. Section 14186.4 of the Welfare and Institutions Code*
17 *is amended to read:*

18 14186.4. (a) This article shall be implemented only to the
19 extent that all necessary federal approvals and waivers have been
20 obtained and only if and to the extent that federal financial
21 participation is available.

22 ~~(b) Notwithstanding any other law, the director, after consulting~~
23 ~~with the Director of Finance, stakeholders, and the Legislature,~~
24 ~~retains the discretion to forgo the provision of services in the~~
25 ~~manner specified in this article in its entirety, or partially, if and~~
26 ~~to the extent that the director determines that the quality of care~~
27 ~~for managed care beneficiaries, efficiency, or cost-effectiveness~~
28 ~~of the program would be jeopardized. In the event the director~~
29 ~~discontinues the provision of services in the manner specified in~~
30 ~~this article, contracts implemented pursuant to this article shall~~
31 ~~accordingly be modified or terminated, to suspend new enrollment~~
32 ~~or disenroll beneficiaries in an orderly manner that provides for~~
33 ~~continuity of care and the safety of beneficiaries.~~

34 (e)

35 (b) To implement this article, the department may contract with
36 public or private entities. Contracts, or amendments to current
37 contracts, entered into under this article may be on a
38 noncompetitive bid basis and shall be exempt from all of the
39 following:

1 (1) Part 2 (commencing with Section 10100) of Division 2 of
2 the Public Contract Code and any policies, procedures, or
3 regulations authorized by that part.

4 (2) Article 4 (commencing with Section 19130) of Chapter 5
5 of Part 2 of Division 5 of Title 2 of the Government Code.

6 (3) Review or approval of contracts by the Department of
7 General Services.

8 (4) Review or approval of feasibility study reports and the
9 requirements of Sections 4819.35 to 4819.37, inclusive, and
10 Sections 4920 to 4928, inclusive, of the State Administrative
11 Manual.

12 ~~(d)~~

13 (c) Notwithstanding Chapter 3.5 (commencing with Section
14 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
15 the State Department of Health Care Services and State Department
16 of Social Services may implement, interpret, or make specific this
17 section by means of all-county letters, plan letters, plan or provider
18 bulletins, or similar instructions, without taking regulatory action.
19 Prior to issuing any letter or similar instrument authorized pursuant
20 to this section, the departments shall notify and consult with
21 stakeholders, including beneficiaries, providers, and advocates.

22 ~~(e)~~

23 (d) Beginning July 1, 2012, the department shall provide the
24 fiscal and appropriate policy committees of the Legislature with
25 a copy of any report submitted to CMS that is required under an
26 approved federal waiver or waiver amendments or any state plan
27 amendment for any LTSS.

28 ~~(f)~~

29 (e) The department shall enter into an interagency agreement
30 with the Department of Managed Health Care to perform some or
31 all of the department's oversight and readiness review activities
32 specified in this article. These activities may include providing
33 consumer assistance to beneficiaries affected by this article, and
34 conducting financial audits, medical surveys, and a review of the
35 provider networks of the managed care health plans participating
36 in this article. The interagency agreement shall be updated, as
37 necessary, on an annual basis in order to maintain functional clarity
38 regarding the roles and responsibilities of the Department of
39 Managed Health Care and the department. The department shall

1 not delegate its authority as the single state Medicaid agency under
 2 this article to the Department of Managed Health Care.

3 ~~(g)~~

4 (f) (1) Beginning with the May Revision to the 2013–14
 5 Governor’s Budget, and annually thereafter, the department shall
 6 report to the Legislature on the enrollment status, quality measures,
 7 and state costs of the actions taken pursuant to this article.

8 (2) (A) By January 1, 2013, or as soon thereafter as practicable,
 9 the department shall develop, in consultation with CMS and
 10 stakeholders, quality and fiscal measures for managed care health
 11 plans to reflect the short- and long-term results of the
 12 implementation of this article. The department shall also develop
 13 quality thresholds and milestones for these measures. The
 14 department shall update these measures periodically to reflect
 15 changes in this program due to implementation factors and the
 16 structure and design of the benefits and services being coordinated
 17 by the health plans.

18 (B) The department shall require managed care health plans to
 19 submit Medicare and Medi-Cal data to determine the results of
 20 these measures. If the department finds that a health plan is not in
 21 compliance with one or more of the measures set forth in this
 22 section, the health plan shall, within 60 days, submit a corrective
 23 action plan to the department for approval. The corrective action
 24 plan shall, at a minimum, include steps that the health plan shall
 25 take to improve its performance based on the standard or standards
 26 with which the health plan is out of compliance. The corrective
 27 action plan shall establish interim benchmarks for improvement
 28 that shall be expected to be met by the health plan in order to avoid
 29 a sanction pursuant to Section 14304. Nothing in this paragraph
 30 is intended to limit the application of Section 14304.

31 (C) The department shall publish the results of these measures,
 32 including via posting on the department’s Internet Web site, on a
 33 quarterly basis.

34 *SEC. 28. Section 14301.1 of the Welfare and Institutions Code*
 35 *is amended to read:*

36 14301.1. (a) For rates established on or after August 1, 2007,
 37 the department shall pay capitation rates to health plans
 38 participating in the Medi-Cal managed care program using actuarial
 39 methods and may establish health-plan- and county-specific rates.
 40 Notwithstanding any other law, this section shall apply to any

1 managed care organization, licensed under the Knox-Keene Health
2 Care Service Plan Act of 1975 (Chapter 2.2 (commencing with
3 Section 1340) of Division 2 of the Health and Safety Code), that
4 has contracted with the department as a primary care case
5 management plan pursuant to Article 2.9 (commencing with
6 Section 14088) of Chapter 7 to provide services to beneficiaries
7 who are HIV positive or who have been diagnosed with AIDS for
8 rates established on or after July 1, 2012. The department shall
9 utilize a county- and model-specific rate methodology to develop
10 Medi-Cal managed care capitation rates for contracts entered into
11 between the department and any entity pursuant to Article 2.7
12 (commencing with Section 14087.3), Article 2.8 (commencing
13 with Section 14087.5), and Article 2.91 (commencing with Section
14 14089) of Chapter 7 that includes, but is not limited to, all of the
15 following:

- 16 (1) Health-plan-specific encounter and claims data.
- 17 (2) Supplemental utilization and cost data submitted by the
18 health plans.
- 19 (3) Fee-for-service data for the underlying county of operation
20 or other appropriate counties as deemed necessary by the
21 department.
- 22 (4) Department of Managed Health Care financial statement
23 data specific to Medi-Cal operations.
- 24 (5) Other demographic factors, such as age, gender, or
25 diagnostic-based risk adjustments, as the department deems
26 appropriate.
- 27 (b) To the extent that the department is unable to obtain
28 sufficient actual plan data, it may substitute plan model, similar
29 plan, or county-specific fee-for-service data.
- 30 (c) The department shall develop rates that include
31 administrative costs, and may apply different administrative costs
32 with respect to separate aid code groups.
- 33 (d) The department shall develop rates that shall include, but
34 are not limited to, assumptions for underwriting, return on
35 investment, risk, contingencies, changes in policy, and a detailed
36 review of health plan financial statements to validate and reconcile
37 costs for use in developing rates.
- 38 (e) The department may develop rates that pay plans based on
39 performance incentives, including quality indicators, access to
40 care, and data submission.

1 (f) The department may develop and adopt condition-specific
2 payment rates for health conditions, including, but not limited to,
3 childbirth delivery.

4 (g) (1) Prior to finalizing Medi-Cal managed care capitation
5 rates, the department shall provide health plans with information
6 on how the rates were developed, including rate sheets for that
7 specific health plan, and provide the plans with the opportunity to
8 provide additional supplemental information.

9 (2) For contracts entered into between the department and any
10 entity pursuant to Article 2.8 (commencing with Section 14087.5)
11 of Chapter 7, the department, by June 30 of each year, or, if the
12 budget has not passed by that date, no later than five working days
13 after the budget is signed, shall provide preliminary rates for the
14 upcoming fiscal year.

15 (h) For the purposes of developing capitation rates through
16 implementation of this ratesetting methodology, Medi-Cal managed
17 care health plans shall provide the department with financial and
18 utilization data in a form and substance as deemed necessary by
19 the department to establish rates. This data shall be considered
20 proprietary and shall be exempt from disclosure as official
21 information pursuant to subdivision (k) of Section 6254 of the
22 Government Code as contained in the California Public Records
23 Act (Division 7 (commencing with Section 6250) of Title 1 of the
24 Government Code).

25 (i) Notwithstanding any other provision of law, on and after the
26 effective date of the act adding this subdivision, the department
27 may apply this section to the capitation rates it pays under any
28 managed care health plan contract.

29 (j) Notwithstanding Chapter 3.5 (commencing with Section
30 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
31 the department may set and implement managed care capitation
32 rates, and interpret or make specific this section and any applicable
33 federal waivers and state plan amendments by means of plan letters,
34 plan or provider bulletins, or similar instructions, without taking
35 regulatory action.

36 (k) The department shall report, upon request, to the fiscal and
37 policy committees of the respective houses of the Legislature
38 regarding implementation of this section.

1 (l) Prior to October 1, 2011, the risk-adjusted countywide
2 capitation rate shall comprise no more than 20 percent of the total
3 capitation rate paid to each Medi-Cal managed care plan.

4 (m) (1) It is the intent of the Legislature to preserve the policy
5 goal to support and strengthen traditional safety net providers who
6 treat high volumes of uninsured and Medi-Cal patients when
7 Medi-Cal enrollees are defaulted into Medi-Cal managed care
8 plans.

9 (2) As the department adds additional factors, such as managed
10 care plan costs, to the Medi-Cal managed care plan default
11 assignment algorithm, it shall consult with the Auto Assignment
12 Performance Incentive Program stakeholder workgroup to develop
13 cost factor disregards related to intergovernmental transfers and
14 required wraparound payments that support safety net providers.

15 (n) *This section shall be inoperative if the Coordinated Care*
16 *Initiative becomes inoperative pursuant to Section 34 of the act*
17 *that added this subdivision.*

18 SEC. 29. *Section 14301.1 is added to the Welfare and*
19 *Institutions Code, to read:*

20 *14301.1. (a) For rates established on or after August 1, 2007,*
21 *the department shall pay capitation rates to health plans*
22 *participating in the Medi-Cal managed care program using*
23 *actuarial methods and may establish health-plan- and*
24 *county-specific rates. The department shall utilize a county- and*
25 *model-specific rate methodology to develop Medi-Cal managed*
26 *care capitation rates for contracts entered into between the*
27 *department and any entity pursuant to Article 2.7 (commencing*
28 *with Section 14087.3), Article 2.8 (commencing with Section*
29 *14087.5), and Article 2.91 (commencing with Section 14089) of*
30 *Chapter 7 that includes, but is not limited to, all of the following:*

31 *(1) Health-plan-specific encounter and claims data.*

32 *(2) Supplemental utilization and cost data submitted by the*
33 *health plans.*

34 *(3) Fee-for-service data for the underlying county of operation*
35 *or other appropriate counties as deemed necessary by the*
36 *department.*

37 *(4) Department of Managed Health Care financial statement*
38 *data specific to Medi-Cal operations.*

1 (5) Other demographic factors, such as age, gender, or
2 diagnostic-based risk adjustments, as the department deems
3 appropriate.

4 (b) To the extent that the department is unable to obtain
5 sufficient actual plan data, it may substitute plan model, similar
6 plan, or county-specific fee-for-service data.

7 (c) The department shall develop rates that include
8 administrative costs, and may apply different administrative costs
9 with respect to separate aid code groups.

10 (d) The department shall develop rates that shall include, but
11 are not limited to, assumptions for underwriting, return on
12 investment, risk, contingencies, changes in policy, and a detailed
13 review of health plan financial statements to validate and reconcile
14 costs for use in developing rates.

15 (e) The department may develop rates that pay plans based on
16 performance incentives, including quality indicators, access to
17 care, and data submission.

18 (f) The department may develop and adopt condition-specific
19 payment rates for health conditions, including, but not limited to,
20 childbirth delivery.

21 (g) (1) Prior to finalizing Medi-Cal managed care capitation
22 rates, the department shall provide health plans with information
23 on how the rates were developed, including rate sheets for that
24 specific health plan, and provide the plans with the opportunity
25 to provide additional supplemental information.

26 (2) For contracts entered into between the department and any
27 entity pursuant to Article 2.8 (commencing with Section 14087.5)
28 of Chapter 7, the department, by June 30 of each year, or, if the
29 budget has not passed by that date, no later than five working days
30 after the budget is signed, shall provide preliminary rates for the
31 upcoming fiscal year.

32 (h) For the purposes of developing capitation rates through
33 implementation of this ratesetting methodology, Medi-Cal managed
34 care health plans shall provide the department with financial and
35 utilization data in a form and substance as deemed necessary by
36 the department to establish rates. This data shall be considered
37 proprietary and shall be exempt from disclosure as official
38 information pursuant to subdivision (k) of Section 6254 of the
39 Government Code as contained in the California Public Records

1 Act (Division 7 (commencing with Section 6250) of Title 1 of the
2 Government Code).

3 (i) The department shall report, upon request, to the fiscal and
4 policy committees of the respective houses of the Legislature
5 regarding implementation of this section.

6 (j) Prior to October 1, 2011, the risk-adjusted countywide
7 capitation rate shall comprise no more than 20 percent of the total
8 capitation rate paid to each Medi-Cal managed care plan.

9 (k) (1) It is the intent of the Legislature to preserve the policy
10 goal to support and strengthen traditional safety net providers
11 who treat high volumes of uninsured and Medi-Cal patients when
12 Medi-Cal enrollees are defaulted into Medi-Cal managed care
13 plans.

14 (2) As the department adds additional factors, such as managed
15 care plan costs, to the Medi-Cal managed care plan default
16 assignment algorithm, it shall consult with the Auto Assignment
17 Performance Incentive Program stakeholder workgroup to develop
18 cost factor disregards related to intergovernmental transfers and
19 required wraparound payments that support safety net providers.

20 (l) This section shall be operative only if Section 28 of the act
21 that added this section becomes inoperative pursuant to subdivision
22 (n) of that Section 28.

23 SEC. 30. Section 10 of Chapter 33 of the Statutes of 2012 is
24 repealed.

25 ~~SEC. 10. (a) In the event the department has not received, by~~
26 ~~February 1, 2013, federal approval, or notification indicating~~
27 ~~pending approval, of a mutual ratesetting process, shared federal~~
28 ~~savings, and a six-month enrollment period in the demonstration~~
29 ~~project pursuant to paragraph (2) of subdivision (l) of Section~~
30 ~~14132.275, effective March 1, 2013, Sections 14132.275, 14182.16,~~
31 ~~and 14182.17, and Article 5.7 (commencing with Section 14186)~~
32 ~~of Chapter 7 shall become inoperative. The director shall execute~~
33 ~~a declaration of these facts and post it on the department's Internet~~
34 ~~Web site.~~

35 (b) For purposes of this section, “shared federal savings” means
36 a methodology that meets the conditions of paragraphs (1) and (2),
37 or paragraph (3).

38 (1) The state and CMS share in the combined savings for
39 Medicare and Medi-Cal, as estimated in the Budget Act of 2012
40 for the 2012–13, 2013–14, 2014–15, and 2015–16 fiscal years.

1 ~~(2) Federal approval for the provisions of paragraphs (2) and~~
2 ~~(3) of subdivision (l) of Section 14132.275 regarding the~~
3 ~~requirement that, upon enrollment in a demonstration site, specified~~
4 ~~beneficiaries shall remain enrolled on a mandatory basis for six~~
5 ~~months from the date of initial enrollment.~~

6 ~~(3) An alternate methodology that, in the determination of the~~
7 ~~Director of Finance, in consultation with the Director of Health~~
8 ~~Care Services and the Joint Legislative Budget Committee, will~~
9 ~~result in the same level of ongoing savings, as estimated in the~~
10 ~~Budget Act of 2012 for the 2012–13, 2013–14, 2014–15, and~~
11 ~~2015–16 fiscal years.~~

12 *SEC. 31. Section 15 of Chapter 45 of the Statutes of 2012 is*
13 *repealed.*

14 ~~SEC. 15. (a) In the event the department has not received, by~~
15 ~~February 1, 2013, federal approval, or notification indicating~~
16 ~~pending approval, of a mutual ratesetting process, shared federal~~
17 ~~savings, and a six-month enrollment period in the demonstration~~
18 ~~project pursuant to Section 14132.275 of the Welfare and~~
19 ~~Institutions Code, effective March 1, 2013, this act shall become~~
20 ~~inoperative, the amendments made to the sections amended by this~~
21 ~~act shall be inoperative, and the sections added by this act shall be~~
22 ~~inoperative. The director shall execute a declaration attesting to~~
23 ~~these facts and post it on the department's Internet Web site.~~

24 ~~(b) For purposes of this section, "shared federal savings" means~~
25 ~~a methodology that meets the conditions of paragraphs (1) and (2);~~
26 ~~or paragraph (3).~~

27 ~~(1) The state and the federal Centers for Medicare and Medicaid~~
28 ~~Services share in the combined savings for Medicare and Medi-Cal,~~
29 ~~as estimated in the Budget Act of 2012 for the 2012–13, 2013–14,~~
30 ~~2014–15, and 2015–16 fiscal years.~~

31 ~~(2) Federal approval for the provisions of Section 14132.275~~
32 ~~of the Welfare and Institutions Code regarding the requirement~~
33 ~~that, upon enrollment in a demonstration site, specified~~
34 ~~beneficiaries shall remain enrolled on a mandatory basis for six~~
35 ~~months from the date of initial enrollment.~~

36 ~~(3) An alternate methodology that, in the determination of the~~
37 ~~Director of Finance, in consultation with the Director of Health~~
38 ~~Care Services and the Joint Legislative Budget Committee, will~~
39 ~~result in the same level of ongoing savings, as estimated in the~~

1 ~~Budget Act of 2012 for the 2012–13, 2013–14, 2014–15, and~~
2 ~~2015–16 fiscal years.~~

3 ~~SEC. 32. Section 16 of Chapter 45 of the Statutes of 2012 is~~
4 ~~repealed.~~

5 ~~SEC. 16. In the event that the conditions set forth in Section~~
6 ~~10 of Assembly Bill 1468 or Senate Bill 1008 of the 2011–12~~
7 ~~Regular Session of the Legislature are not met as described and~~
8 ~~the provisions of law set forth in Section 10 of those bills become~~
9 ~~inoperative, Sections 6531.5 and Title 23 (commencing with~~
10 ~~Section 110000) of the Government Code and Sections 12300.5,~~
11 ~~12300.6, 12300.7, and 12302.6 of the Welfare and Institutions~~
12 ~~Code as added by this act shall become inoperative as of March~~
13 ~~1, 2013.~~

14 ~~SEC. 33. Section 17 of Chapter 45 of the Statutes of 2012, as~~
15 ~~amended by Section 45 of Chapter 439 of the Statutes of 2012, is~~
16 ~~repealed.~~

17 ~~Sec. 17. In the event the director decides to entirely forego the~~
18 ~~provision of services as specified in Section 14186.4 of the Welfare~~
19 ~~and Institutions Code, Section 6531.5 and Title 23 (commencing~~
20 ~~with Section 110000) of the Government Code and Sections~~
21 ~~12300.5, 12300.6, and 12300.7 of the Welfare and Institutions~~
22 ~~Code as added by this act shall cease to be implemented except as~~
23 ~~follows:~~

24 ~~(a) For an agreement that has been negotiated and approved by~~
25 ~~the Statewide Authority, the Statewide Authority shall continue~~
26 ~~to retain its authority pursuant to Section 6531.5 and Title 23~~
27 ~~(commencing with Section 110000) of the Government Code and~~
28 ~~Sections 12300.5, 12300.6, 12300.7, and 12302.6 of the Welfare~~
29 ~~and Institutions Code as added by this act, and remain the employer~~
30 ~~of record for all individual providers covered by the agreement~~
31 ~~until the agreement expires or is subject to renegotiation, whereby~~
32 ~~the authority of the Statewide Authority shall terminate and the~~
33 ~~county shall be the employer of record in accordance with Section~~
34 ~~12302.25 of the Welfare and Institutions Code and may establish~~
35 ~~an employer of record pursuant to Section 12301.6 of the Welfare~~
36 ~~and Institutions Code.~~

37 ~~(b) For an agreement that has been assumed by the Statewide~~
38 ~~Authority that was negotiated and approved by a predecessor~~
39 ~~agency, the Statewide Authority shall cease being the employer~~
40 ~~of record and the county shall be reestablished as the employer of~~

1 ~~record for purposes of bargaining and in accordance with Section~~
2 ~~12302.25 of the Welfare and Institutions Code, and may establish~~
3 ~~an employer of record pursuant to Section 12301.6 of the Welfare~~
4 ~~and Institutions Code.~~

5 *SEC. 34. (a) At least 30 days prior to enrollment of*
6 *beneficiaries into the Coordinated Care Initiative, the Director of*
7 *Finance shall estimate the amount of net General Fund savings*
8 *obtained from the implementation of the Coordinated Care*
9 *Initiative. This estimate shall take into account any net savings to*
10 *the General Fund achieved through the tax imposed pursuant to*
11 *Article 5 (commencing with Section 6174) of Chapter 2 of Part 1*
12 *of Division 2 of the Revenue and Taxation Code Article 5*
13 *(commencing with Section 6174).*

14 *(b) (1) By January 10 for each fiscal year after implementation*
15 *of the Coordinated Care Initiative, for as long as the Coordinated*
16 *Care Initiative remains operative, the Director of Finance shall*
17 *estimate the amount of net General Fund savings obtained from*
18 *the implementation of the Coordinated Care Initiative.*

19 *(2) Savings shall be determined under this subdivision by*
20 *comparing the estimated costs of the Coordinated Care Initiative,*
21 *as approved by the federal government, and the estimated costs*
22 *of the program if the Coordinated Care Initiative were not*
23 *operative. The determination shall also include any net savings to*
24 *the General Fund achieved through the tax imposed pursuant to*
25 *Article 5 (commencing with Section 6174) of Chapter 2 of Part 1*
26 *of Division 2 of the Revenue and Taxation Code.*

27 *(3) The estimates prepared by the Director of Finance, in*
28 *consultation with the Director of Health Care Services, shall be*
29 *provided to the Legislature.*

30 *(c) (1) Notwithstanding any other law, if, at least 30 days prior*
31 *to enrollment of beneficiaries into the Coordinated Care Initiative,*
32 *the Director of Finance estimates pursuant to subdivision (a) that*
33 *the Coordinated Care Initiative will not generate net General Fund*
34 *Savings, then the activities to implement the Coordinated Care*
35 *Initiative shall be suspended immediately and the Coordinated*
36 *Care Initiative shall become inoperative July 1, 2014.*

37 *(2) If the Coordinated Care Initiative becomes inoperative*
38 *pursuant to this subdivision, the Director of Health Care Services*
39 *shall provide any necessary notifications to any affected entities.*

1 (3) For purposes of this subdivision and subdivision (d) only,
2 “Coordinated Care Initiative” means all of the following statutes
3 and any amendments to the following:

4 (A) Sections 14132.275, 14183.6, and 14301.1 of the Welfare
5 and Institutions Code, as amended by this act.

6 (B) Sections 14132.276, 14132.277, 14182.16, 14182.17,
7 14182.18, and 14301.2 of the Welfare and Institutions Code.

8 (C) Article 5.7 (commencing with Section 14186) of Chapter 7
9 of Part 3 of Division 9 of the Welfare and Institutions Code.

10 (D) Title 23 (commencing with Section 110000) of the
11 Government Code.

12 (E) Section 6531.5 of the Government Code.

13 (F) Section 6253.2 of the Government Code, as amended by
14 this act.

15 (G) Sections 12300.5, 12300.6, 12300.7, 12302.6, 12306.15,
16 12330, 14186.35, and 14186.36 of the Welfare and Institutions
17 Code.

18 (H) Sections 10101.1, 12306, and 12306.1 of the Welfare and
19 Institutions Code, as amended by this act.

20 (I) The amendments made to Sections 12302.21 and 12302.25
21 of the Welfare and Institutions Code, as made by Chapter 439 of
22 the Statutes of 2012.

23 (d) (1) Notwithstanding any other law, and beginning in 2015,
24 if the Director of Finance estimates pursuant to subdivision (b)
25 that the Coordinated Care Initiative will not generate net General
26 Fund savings, the Coordinated Care Initiative shall become
27 inoperative January 1 of the following calendar year, except as
28 follows:

29 (A) Section 12306.15 of the Welfare and Institutions Code shall
30 become inoperative as of July 1 of that same calendar year.

31 (B) For any agreement that has been negotiated and approved
32 by the Statewide Authority, the Statewide Authority shall continue
33 to retain its authority pursuant to Section 6531.5 and Title 23
34 (commencing with Section 110000) of the Government Code and
35 Sections 12300.5, 12300.6, 12300.7, and 12302.6 of the Welfare
36 and Institutions Code, and shall remain the employer of record
37 for all individual providers covered by the agreement until the
38 agreement expires or is subject to renegotiation, whereby the
39 authority of the Statewide Authority shall terminate and the county
40 shall be the employer of record in accordance with Section

1 12302.25 of the Welfare and Institutions Code and may establish
2 an employer of record pursuant to Section 12301.6 of the Welfare
3 and Institutions Code.

4 (C) For an agreement that has been assumed by the Statewide
5 Authority that was negotiated and approved by a predecessor
6 agency, the Statewide Authority shall cease being the employer of
7 record and the county shall be reestablished as the employer of
8 record for purposes of bargaining and in accordance with Section
9 12302.25 of the Welfare and Institutions Code, and may establish
10 an employer of record pursuant to Section 12301.6 of the Welfare
11 and Institutions Code.

12 (2) If the Coordinated Care Initiative becomes inoperative
13 pursuant to this subdivision, the Director of Health Care Services
14 shall provide any necessary notifications to any affected entities.

15 SEC. 35. For the purpose of the Coordinated Care Initiative,
16 the amount of five hundred thousand dollars (\$500,000) is hereby
17 appropriated from the General Fund to the State Department of
18 Health Care Services for purposes of notifying dual eligible
19 beneficiaries and providers regarding the provisions of this Act,
20 and shall be available for encumbrance and expenditure until June
21 30, 2014.

22 SEC. 36. This act is a bill providing for appropriations related
23 to the Budget Bill within the meaning of subdivision (e) of Section
24 12 of Article IV of the California Constitution, has been identified
25 as related to the budget in the Budget Bill, and shall take effect
26 immediately.

27 SECTION 1. ~~It is the intent of the Legislature to enact statutory~~
28 ~~changes relating to the Budget Act of 2013.~~