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:

SECTION 1. Section 6253.2 of the Government Code, as amended by Section 2 of Chapter 439 of the Statutes of 2012, is amended to read:

6253.2. (a) Notwithstanding any other provision of this chapter to the contrary, information regarding persons paid by the state to provide in-home supportive services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code, or services provided pursuant to Section 14132.95, 14132.952, or 14132.956 of the Welfare and Institutions Code, ~~shall~~ *is* not ~~be~~ subject to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 3. [Reserved]

SEC. 4. [Reserved]

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

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

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

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

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

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

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

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

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

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

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

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

12300.7. (a) No sooner than March 1, 2013, the California In-Home Supportive Services Authority shall assume the responsibilities set forth in Title 23 (commencing with Section 110000) of the Government Code 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 ~~Sections 14132.275,~~ *Section 14132.275 or* 14182.16, ~~and 14182.17~~ *or Article 5.7 (commencing with Section 14186) of Chapter 7* has been completed in that county or city and county.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) "D-SNP plan" means a Medicare Advantage Special Needs Plan.

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

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

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

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

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

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

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

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

(1) "Coordinated Care Initiative counties" means the Counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

~~(1)~~

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

~~(2)~~

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

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

~~(3)~~

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

~~(4)~~

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

~~(5)~~

(6) "Out-of-network Medi-Cal provider" means a health care provider that does not have an existing contract with the beneficiary's managed care health plan or its subcontractors.

~~(6)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) The plan choices.

(II) Continuity of care provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

as part of the beneficiary's care management plan when appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Submit to the Legislature the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ix) Develop continuity of care procedures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that reduces the unnecessary use of emergency and hospital services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(a)~~

(b) "Home- and community-based services" means services provided pursuant to paragraphs (1), (2), and (3) of subdivision ~~(b)~~ *(c)*.

~~(b)~~

(c) "Long-term services and supports" or "LTSS" means all of the following:

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

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

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

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

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

~~(c)~~

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

~~(d)~~

(e) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200). For the purposes of this article, "managed care health plan" shall not include an individual, organization, or entity that enters into a contract with the department to provide services pursuant to Chapter 8.75 (commencing with Section 14591) or the Senior Care Action Network.

~~(e)~~

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

~~(f)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) The criteria for reassessment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c)~~

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

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

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

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

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

~~(d)~~

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

~~(e)~~

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

~~(f)~~

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

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

~~(g)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 10. (a) In the event 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 six-month enrollment period in the demonstration project pursuant to paragraph (2) of subdivision (*l*) of Section 14132.275, effective March 1, 2013, Sections 14132.275, 14182.16, and 14182.17, and Article 5.7 (commencing with Section 14186) of Chapter 7 shall become inoperative. The director shall execute a declaration of these facts and post it on the department's Internet Web site.~~

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

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

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

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

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

~~SEC. 15. (a) In the event 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 six-month enrollment period in the demonstration project pursuant to Section 14132.275 of the Welfare and Institutions Code, effective March 1, 2013, this act shall become inoperative, the amendments made to the sections amended by this act shall be inoperative, and the sections added by this act shall be inoperative. The director shall execute a declaration attesting to these facts and post it on the department's Internet Web site.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Section 6531.5 of the Government Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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