

Assembly Bill No. 776

CHAPTER 298

An act to amend Sections 14186.1, 14186.36, and 14186.4 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 9, 2013. Filed with
Secretary of State September 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 776, Yamada. Medi-Cal.

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, to the extent that federal financial participation is available, and pursuant to a demonstration project or waiver of federal law, the department to establish specified pilot projects in up to 8 counties, and requires long-term services and supports, as defined, to be available to beneficiaries residing in Coordinated Care Initiative counties, as specified.

In implementing the requirements that beneficiaries residing in Coordinated Care Initiative counties be provided long-term services and supports, existing law requires the department to consult stakeholders. For the purposes of existing law, specified terms are defined.

This bill would additionally define the term "stakeholder" to include area agencies on aging and independent living centers. The bill would also make related conforming changes.

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

SECTION 1. Section 14186.1 of the Welfare and Institutions Code, as amended by Section 22 of Chapter 37 of the Statutes of 2013, 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.

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

(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.

(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.

(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.

(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.

(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.

(h) “Stakeholder” shall include, but shall not be limited to, area agencies on aging and independent living centers.

SEC. 2. Section 14186.36 of the Welfare and Institutions Code, as amended by Section 26 of Chapter 37 of the Statutes of 2013, 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 (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, area agencies on aging, independent living centers, 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) This section shall remain operative only until July 1, 2017.

SEC. 3. Section 14186.4 of the Welfare and Institutions Code, as amended by Section 27 of Chapter 37 of the Statutes of 2013, 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) 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.

(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, area agencies on aging, independent living centers, and advocates.

(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 the federal Centers for Medicare and Medicaid Services (CMS) that is required under an approved federal waiver or waiver amendments or any state plan amendment for any LTSS.

(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.

(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.

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