

AMENDED IN SENATE JUNE 1, 2015
AMENDED IN ASSEMBLY APRIL 21, 2015
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 461

**Introduced by Assembly Member Mullin
(Coauthor: Assembly Member Gordon)
(Coauthor: Senator Hill)**

February 23, 2015

An act to amend Section 14132.275 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 461, as amended, Mullin. Coordinated Care Initiative.

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. One of the methods by which these services are provided is pursuant to contracts with various types of managed care health plans. Existing federal law provides for the federal Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age.

Existing law requires the department to seek federal approval pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination thereof, to establish a demonstration project that enables beneficiaries dually eligible for the Medi-Cal program and the Medicare Program to receive a continuum of services that maximizes access to,

and coordination of, benefits between the programs. Existing law requires, with some exceptions, the department to enroll dual eligible beneficiaries into a managed care plan that is selected to participate in the demonstration project unless the beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled in a specified managed care organization on or before June 1, 2013. Existing law excludes a dual eligible beneficiary from enrollment in the demonstration project if, among other reasons, the beneficiary is receiving services through a regional center or state developmental center. *Existing law also excludes a dual eligible beneficiary from enrollment in the demonstration project if, among other reasons, the beneficiary is enrolled in a home- and community-based waiver except for persons enrolled in Multipurpose Senior Services Program services.*

This bill would authorize a beneficiary receiving services through a regional center who resides in the County of San Mateo to participate voluntarily in the demonstration project if certain requirements are met.

This bill would make legislative findings and declarations as to the necessity of a special statute for the County of San Mateo.

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

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

1 SECTION 1. Section 14132.275 of the Welfare and Institutions
2 Code, as amended by Section 51 of Chapter 31 of the Statutes of
3 2014, is amended to read:
4 14132.275. (a) The department shall seek federal approval to
5 establish the demonstration project described in this section
6 pursuant to a Medicare or a Medicaid demonstration project or
7 waiver, or a combination thereof. Under a Medicare demonstration,
8 the department may contract with the federal Centers for Medicare
9 and Medicaid Services (CMS) and demonstration sites to operate
10 the Medicare and Medicaid benefits in a demonstration project
11 that is overseen by the state as a delegated Medicare benefit
12 administrator, and may enter into financing arrangements with
13 CMS to share in any Medicare program savings generated by the
14 demonstration project.
15 (b) After federal approval is obtained, the department shall
16 establish the demonstration project that enables dual eligible
17 beneficiaries to receive a continuum of services that maximizes

1 access to, and coordination of, benefits between the Medi-Cal and
2 Medicare programs and access to the continuum of long-term
3 services and supports and behavioral health services, including
4 mental health and substance use disorder treatment services. The
5 purpose of the demonstration project is to integrate services
6 authorized under the federal Medicaid Program (Title XIX of the
7 federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the
8 federal Medicare Program (Title XVIII of the federal Social
9 Security Act (42 U.S.C. Sec. 1395 et seq.)). The demonstration
10 project may also include additional services as approved through
11 a demonstration project or waiver, or a combination thereof.

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

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

20 (2) “Capitated payment model” means an agreement entered
21 into between CMS, the state, and a managed care health plan, in
22 which the managed care health plan receives a capitation payment
23 for the comprehensive, coordinated provision of Medi-Cal services
24 and benefits under Medicare Part C (42 U.S.C. Sec. 1395w-21 et
25 seq.) and Medicare Part D (42 U.S.C. Sec. 1395w-101 et seq.),
26 and CMS shares the savings with the state from improved provision
27 of Medi-Cal and Medicare services that reduces the cost of those
28 services. Medi-Cal services include long-term services and supports
29 as defined in Section 14186.1, behavioral health services, and any
30 additional services offered by the demonstration site.

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

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

39 (d) No sooner than March 1, 2011, the department shall identify
40 health care models that may be included in the demonstration

1 project, shall develop a timeline and process for selecting,
2 financing, monitoring, and evaluating the demonstration sites, and
3 shall provide this timeline and process to the appropriate fiscal
4 and policy committees of the Legislature. The department may
5 implement these demonstration sites in phases.

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

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

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

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

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

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

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

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

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

33 (g) No sooner than March 1, 2013, demonstration sites shall be
34 established in up to eight counties, and shall include at least one
35 county that provides Medi-Cal services via a two-plan model
36 pursuant to Article 2.7 (commencing with Section 14087.3) and
37 at least one county that provides Medi-Cal services under a county
38 organized health system pursuant to Article 2.8 (commencing with
39 Section 14087.5). The director shall consult with the Legislature,
40 CMS, and stakeholders when determining the implementation date

1 for this section. In determining the counties in which to establish
2 a demonstration site, the director shall consider the following:

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

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

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

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

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

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

27 (B) Be in good financial standing and meet licensure
28 requirements under the Knox-Keene Health Care Service Plan Act
29 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division
30 2 of the Health and Safety Code), except for county organized
31 health system plans that are exempt from licensure pursuant to
32 Section 14087.95.

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

37 (D) Demonstrate a local stakeholder process that includes dual
38 eligible beneficiaries, managed care health plans, providers, mental
39 health representatives, county health and human services agencies,
40 designated representatives of in-home supportive services

1 personnel, and other interested stakeholders that advise and consult
2 with the demonstration site in the development, implementation,
3 and continued operation of the demonstration project.

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

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

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

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

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

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

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

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

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

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

31 (9) To the extent permissible under federal requirements,
32 implementation of the provisions of Sections 14182.16 and
33 14182.17 that are applicable to beneficiaries simultaneously eligible
34 for full-scope benefits under Medi-Cal and the Medicare Program.

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

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

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

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

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

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

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

23 (iii) To the extent permissible under federal requirements,
24 comply with the provisions of Sections 14182.16 and 14182.17
25 that are applicable to beneficiaries simultaneously eligible for
26 full-scope benefits under both Medi-Cal and the Medicare Program.

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

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

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

36 (k) The director may enter into exclusive or nonexclusive
37 contracts on a bid or negotiated basis and may amend existing
38 managed care contracts to provide or arrange for services provided
39 under this section. Contracts entered into or amended pursuant to
40 this section shall be exempt from the provisions of Chapter 2

1 (commencing with Section 10290) of Part 2 of Division 2 of the
2 Public Contract Code and Chapter 6 (commencing with Section
3 14825) of Part 5.5 of Division 3 of Title 2 of the Government
4 Code.

5 (D) (1) (A) Except for the exemptions provided for in this
6 section and in Section 14132.277, the department shall enroll dual
7 eligible beneficiaries into a demonstration site unless the
8 beneficiary makes an affirmative choice to opt out of enrollment
9 or is already enrolled on or before June 1, 2013, in a managed care
10 organization licensed under the Knox-Keene Health Care Service
11 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)
12 of Division 2 of the Health and Safety Code) that has previously
13 contracted with the department as a primary care case management
14 plan pursuant to Article 2.9 (commencing with Section 14088) to
15 provide services to beneficiaries who are HIV positive or who
16 have been diagnosed with AIDS or in any entity with a contract
17 with the department pursuant to Chapter 8.75 (commencing with
18 Section 14591).

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

25 (C) (i) Persons meeting requirements for the Program of
26 All-Inclusive Care for the Elderly (PACE) pursuant to Chapter
27 8.75 (commencing with Section 14591) or a managed care
28 organization licensed under the Knox-Keene Health Care Service
29 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)
30 of Division 2 of the Health and Safety Code) that has previously
31 contracted with the department as a primary care case management
32 plan pursuant to Article 2.9 (commencing with Section 14088) of
33 Chapter 7 to provide services to beneficiaries who are HIV positive
34 or who have been diagnosed with AIDS may select either of these
35 managed care health plans for their Medicare and Medi-Cal benefits
36 if one is available in that county.

37 (ii) In areas where a PACE plan is available, the PACE plan
38 shall be presented as an enrollment option, included in all
39 enrollment materials, enrollment assistance programs, and outreach
40 programs related to the demonstration project, and made available

1 to beneficiaries whenever enrollment choices and options are
2 presented. Persons meeting the age qualifications for PACE and
3 who choose PACE shall remain in the fee-for-service Medi-Cal
4 and Medicare programs, and shall not be assigned to a managed
5 care health plan for the lesser of 60 days or until they are assessed
6 for eligibility for PACE and determined not to be eligible for a
7 PACE plan. Persons enrolled in a PACE plan shall receive all
8 Medicare and Medi-Cal services from the PACE program pursuant
9 to the three-way agreement between the PACE program, the
10 department, and the Centers for Medicare and Medicaid Services.

11 (2) To the extent that federal approval is obtained, the
12 department may require that any beneficiary, upon enrollment in
13 a demonstration site, remain enrolled in the Medicare portion of
14 the demonstration project on a mandatory basis for six months
15 from the date of initial enrollment. After the sixth month, a dual
16 eligible beneficiary may elect to enroll in a different demonstration
17 site, a different Medicare Advantage plan, fee-for-service Medicare,
18 PACE, or a managed care organization licensed under the
19 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
20 (commencing with Section 1340) of Division 2 of the Health and
21 Safety Code) that has previously contracted with the department
22 as a primary care case management plan pursuant to Article 2.9
23 (commencing with Section 14088) to provide services to
24 beneficiaries who are HIV positive or who have been diagnosed
25 with AIDS, for his or her Medicare benefits.

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

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

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

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

38 (B) The department shall develop a process to inform providers
39 and beneficiaries of the availability of continuity of services from

1 an existing provider and ensure that the beneficiary continues to
2 receive services without interruption.

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

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

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

15 (iii) The beneficiary is enrolled in a home- and community-based
16 waiver that is a Medi-Cal benefit under Section 1915(c) of the
17 federal Social Security Act (42 U.S.C. Sec. 1396n et seq.), except
18 for persons enrolled in Multipurpose Senior Services Program
19 ~~services~~. *services or beneficiaries receiving services through a*
20 *regional center who resides in the County of San Mateo.*

21 (iv) The beneficiary is receiving services through a regional
22 center or state developmental center. However, a beneficiary
23 receiving services through a regional center who resides in the
24 County of San Mateo, by making an affirmative choice to opt in,
25 may voluntarily enroll in the demonstration project, upon receipt
26 of all legal notifications required pursuant to this section and
27 applicable federal requirements.

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

31 (vi) The beneficiary resides in one of the Veterans' Homes of
32 California, as described in Chapter 1 (commencing with Section
33 1010) of Division 5 of the Military and Veterans Code.

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

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

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

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

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

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

19 (4) For the 2013 calendar year, the department shall offer federal
20 Medicare Improvements for Patients and Providers Act of 2008
21 (Public Law 110-275) compliant contracts to existing Medicare
22 Advantage Dual Special Needs Plans (D-SNP plans) to continue
23 to provide Medicare benefits to their enrollees in their service areas
24 as approved on January 1, 2012. In the 2013 calendar year,
25 beneficiaries in Medicare Advantage and D-SNP plans shall be
26 exempt from the enrollment provisions of subparagraph (A) of
27 paragraph (1), but may voluntarily choose to enroll in the
28 demonstration project. Enrollment into the demonstration project's
29 managed care health plans shall be reassessed in 2014 depending
30 on federal reauthorization of the D-SNP model and the
31 department's assessment of the demonstration plans.

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

35 (6) The department shall not terminate contracts in a
36 demonstration site with a managed care organization licensed
37 under the Knox-Keene Health Care Service Plan Act of 1975
38 (Chapter 2.2 (commencing with Section 1340) of Division 2 of
39 the Health and Safety Code) that has previously contracted with
40 the department as a primary care case management plan pursuant

1 to Article 2.9 (commencing with Section 14088) to provide services
2 to beneficiaries who are HIV positive beneficiaries or who have
3 been diagnosed with AIDS and with any entity with a contract
4 pursuant to Chapter 8.75 (commencing with Section 14591), except
5 as provided in the contract or pursuant to state or federal law.

6 (m) Notwithstanding Section 10231.5 of the Government Code,
7 the department shall conduct an evaluation, in partnership with
8 CMS, to assess outcomes and the experience of dual eligibles in
9 these demonstration sites and shall provide a report to the
10 Legislature after the first full year of demonstration operation, and
11 annually thereafter. A report submitted to the Legislature pursuant
12 to this subdivision shall be submitted in compliance with Section
13 9795 of the Government Code. The department shall consult with
14 stakeholders regarding the scope and structure of the evaluation.

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

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

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

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

24 (3) Reimbursement policies shall not prevent demonstration
25 sites and providers from entering into payment arrangements that
26 allow for the alignment of financial incentives and provide
27 opportunities for shared risk and shared savings in order to promote
28 appropriate utilization shifts, which encourage the use of home-
29 and community-based services and quality of care for dual eligible
30 beneficiaries enrolled in the demonstration sites.

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

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

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

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

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

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

19 (p) The department shall enter into an interagency agreement
20 with the Department of Managed Health Care to perform some or
21 all of the department's oversight and readiness review activities
22 specified in this section. These activities may include providing
23 consumer assistance to beneficiaries affected by this section and
24 conducting financial audits, medical surveys, and a review of the
25 adequacy of provider networks of the managed care health plans
26 participating in this section. The interagency agreement shall be
27 updated, as necessary, on an annual basis in order to maintain
28 functional clarity regarding the roles and responsibilities of the
29 Department of Managed Health Care and the department. The
30 department shall not delegate its authority under this section as
31 the single state Medicaid agency to the Department of Managed
32 Health Care.

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

37 (2) (A) By January 1, 2013, or as soon thereafter as practicable,
38 the department shall develop, in consultation with CMS and
39 stakeholders, quality and fiscal measures for health plans to reflect
40 the short- and long-term results of the implementation of this

1 section. The department shall also develop quality thresholds and
2 milestones for these measures. The department shall update these
3 measures periodically to reflect changes in this program due to
4 implementation factors and the structure and design of the benefits
5 and services being coordinated by managed care health plans.

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

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

22 (r) Notwithstanding Chapter 3.5 (commencing with Section
23 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
24 the department may implement, interpret, or make specific this
25 section and any applicable federal waivers and state plan
26 amendments by means of all-county letters, plan letters, plan or
27 provider bulletins, or similar instructions, without taking regulatory
28 action. Prior to issuing any letter or similar instrument authorized
29 pursuant to this section, the department shall notify and consult
30 with stakeholders, including advocates, providers, and
31 beneficiaries. The department shall notify the appropriate policy
32 and fiscal committees of the Legislature of its intent to issue
33 instructions under this section at least five days in advance of the
34 issuance.

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

38 SEC. 2. The Legislature finds and declares that a special law
39 is necessary and that a general law cannot be made applicable
40 within the meaning of Section 16 of Article IV of the California

- 1 Constitution because of the unique circumstances regarding the
- 2 availability of resources for dual eligible beneficiaries in the
- 3 County of San Mateo.

O