AMENDED IN SENATE AUGUST 24, 2012

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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 2206

Introduced by Assembly Member Atkins

February 23, 2012

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2206, as amended, Atkins. Medi-Cal: dual eligibles: pilot projects.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. 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, to the extent that federal financial participation is available, and pursuant to a demonstration project or waiver of federal law, requires the department to establish demonstration sites to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs. Under existing law, the department may require persons who are dually eligible to enroll in a Medi-Cal managed care plan that is

established or expanded as part of a demonstration project, except as specified. Existing law also requires a person who is eligible for the California Program of All-Inclusive Care for the Elderly (PACE), which provides specified long-term care services to qualified older individuals, to be presented with a PACE plan as an enrollment option, in areas where a PACE plan is available.

This bill would authorize persons ~~who are enrolled in a PACE plan to continue to receive their Medi-Cal and Medicare benefits through the PACE plan without having to reselect the plan, and authorize persons~~ who are eligible for PACE to disenroll from a managed care health plan and enroll in a PACE plan at any time to receive their *Medi-Cal and Medicare* benefits. This bill would require managed care health plans to identify, in their assessments of enrollees, and notify~~,~~ certain beneficiaries of their potential eligibility for PACE.

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

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

SECTION 1. 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~~ *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 noncontracting 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.

~~(iii) Persons who are already enrolled in a PACE plan at the time of the enrollment period for the demonstration project shall remain in and continue to receive their Medi-Cal and Medicare benefits through the PACE plan, and shall not be provided with enrollment materials or required to select the PACE plan to remain in the plan.~~

~~(iv)~~

(iii) Notwithstanding any enrollment lock-in that may apply to the demonstration project for receipt of Medi-Cal or Medicare benefits, persons who become eligible for PACE and are enrolled in a managed care *health* plan are authorized to disenroll from the plan and enroll in a PACE plan at any time to receive their Medi-Cal and Medicare benefits.

~~(v)~~

(iv) Managed care health plans shall identify in their assessments of enrollees that occur during the transition to managed care and at regularly scheduled intervals beneficiaries who are 55 years of age and older who are at risk of being placed in a nursing home. Managed care health plans shall notify these beneficiaries of their potential eligibility for PACE.

(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 (1), 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) 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 Community-Based Adult Services or 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.

(III) To county administrators of the local low-income health programs (LIHPs).

(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~~ *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.

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