

AMENDED IN ASSEMBLY AUGUST 23, 2012

SENATE BILL

No. 1019

Introduced by Committee on Budget and Fiscal Review

February 6, 2012

~~An act relating to the Budget Act of 2012.~~ *An act to amend Sections 8803 and 56475 of the Education Code, to amend Sections 12803.65, 95001, 95003, 95012, and 95020 of the Government Code, to amend Section 124174.2 of the Health and Safety Code, and to amend Sections 4510, 5213, 5256.1, 5875, 14005.26, 14005.27, 14105.18, 14105.196, 14132.24, 14132.275, 14132.276, 14139.22, 14166.12, 14166.17, 14182.16, 14182.17, 14183.6, 14186.2, 14301.1, 14301.2, and 15912.1 of the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1019, as amended, Committee on Budget and Fiscal Review.
~~Budget Act of 2012.~~ *Health.*

(1) Under existing law, the State Department of Health Care Services is authorized and required to perform various functions relating to the care and treatment of persons with mental disorders. Under existing law, services for these individuals may be provided in psychiatric hospitals or other types of facilities, as well as in community settings. Under existing law, psychiatric health facilities are licensed and regulated by the State Department of Social Services. Existing law provides for state hospitals for the care, treatment, and education of mentally disordered persons, which are under the jurisdiction of the State Department of State Hospitals.

This bill would make technical, nonsubstantive changes to various provisions of law to, in part, delete obsolete references to the State Department of Mental Health.

(2) Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board (MRMIB), to arrange for the provision of health, vision, and dental benefits to eligible children pursuant to the federal Children's Health Insurance Program. Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law provides for the transition of specified enrollees of the Healthy Families Program to the Medi-Cal program, to the extent that those individuals are otherwise eligible, no sooner than January 1, 2013. Existing law requires this transition to take place in 4 phases, as prescribed. Existing law requires the Department of Health Care Services to exercise the option to provide full-scope benefits with no share of cost to children who have attained 6 years of age but have not attained 19 years of age and who are optional targeted low-income children, as specified.

This bill would delete the age restriction on the option to provide full-scope benefits to optional targeted low-income children. The bill would modify the monthly premiums imposed under these provisions, and would authorize the State Department of Health Care Services to enter into and continue contracts with the Health Families Program administrative vendor for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to these children. This bill would authorize the State Department of Health Care Services to enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities and would make other changes related to the implementation of these provisions.

(3) Existing law requires, to the extent required by federal law, and beginning January 1, 2013, through and including December 31, 2014, that payments for primary care services provided by specified physicians be no less than 100% of the payment rate that applies to those services and physicians as established by the Medicare Program, for both fee-for-service and managed care plans.

This bill would provide that payment increases made pursuant to these provisions shall not apply to certain provider rates of payment.

(4) One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care health plans. Existing law, to the extent that federal financial participation is available, and pursuant to a demonstration project or waiver of federal law, requires the State Department of Health Care Services to establish demonstration sites, as defined, in up to 8 counties no sooner than March 1, 2013, to enable beneficiaries eligible under both the Medi-Cal and Medicare programs to receive a continuum of services that maximizes access to the continuum of long-term services and supports and behavioral health services. Existing law requires the department, with exceptions, to enroll dual eligible beneficiaries into a demonstration site unless the dual eligible beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled in specific entities, as specified.

This bill would modify the criteria that must be met to be excluded from enrollment in the demonstration project and would modify the provisions relating to the disclosure of information relating to beneficiaries who have been diagnosed with HIV/AIDS.

Existing law requires the State Department of Health Care Services to ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries residing in counties participating in the demonstration project.

This bill would delete the requirement under these provisions that the Department of Managed Health Care monitor whether beneficiaries are able to receive timely access to primary and specialty care services as prescribed.

(5) Existing law requires the department to enter into an interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks of the managed care plans participating in a certain demonstration project and provide consumer assistance to beneficiaries affected by certain provisions.

This bill would additionally require the department to enter into an interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks in connection with the expansion of Medi-Cal managed care into rural counties.

(6) Existing law requires the department to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and authorizes the department to establish health-plan- and county-specific rates, as specified.

This bill would provide that 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, as specified.

(7) Existing law authorizes, to the extent consistent with federal law, the State Department of Health Care Services to defer payments to Medi-Cal managed care health plans and providers, as applicable, contracting with the department, as specified, which are payable to the plans during the final month of the 2012–13 state fiscal year, if certain conditions are satisfied.

This bill would modify these provisions to eliminate the limitation of the deferral to the 2012–13 state fiscal year and would additionally authorize the State Department of Health Care Services to defer fee-for-service payments under these provisions.

(8) Existing law requires the State Department of Health Care Services, in collaboration with the State Department of Public Health, and in consultation with stakeholders, to develop policies and guidance on the transition of persons diagnosed with HIV/AIDS from programs funded under the federal Ryan White Act to the Low Income Health Program (LIHP).

This bill would, for purposes of implementing LIHP, authorize the State Department of Public Health to share relevant data related to a beneficiary's enrollment in federal Ryan White Act funded programs who may be eligible for LIHP services, and would authorize a participating entity, as defined, to share relevant data relating to persons diagnosed with HIV/AIDS with the State Department of Public Health, as prescribed.

(9) This bill would appropriate \$1,000 to the State Department of Health Care Services for administration.

(10) 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 2012.~~

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

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

1 *SECTION 1. Section 8803 of the Education Code is amended*
2 *to read:*

3 8803. In order to encourage the integration of children's
4 services, it is the intent of the Legislature to promote interagency
5 coordination and collaboration among the state agencies
6 responsible for the provision of support services to children and
7 their families.

8 Therefore, the Legislature hereby establishes the Healthy Start
9 Support Services for Children Program Council, as follows:

10 (a) Members of the council shall include the Superintendent,
11 the agency secretary, and the directors of the State Department of
12 Health Care Services, the State Department of Social Services,
13 *and the State Department of Alcohol and Drug Programs, and the*
14 ~~State Department of Mental Health.~~

15 (b) Duties of the council shall include:

16 (1) Developing, promoting, and implementing policy supporting
17 the Healthy Start Support Services for Children Grant Program.

18 (2) Assisting the lead agency in reviewing grant applications
19 submitted to the lead agency and providing the lead agency with
20 recommendations for awarding grants pursuant to Section 8804.

21 (3) Soliciting input regarding program policy and direction from
22 individuals and entities with experience in the integration of
23 children's services.

24 (4) Assisting the lead agency in fulfilling its responsibilities
25 under this chapter.

26 (5) Providing recommendations to the Governor, the Legislature,
27 and the lead agency regarding the Healthy Start Support Services
28 for Children Grant Program.

29 (6) At the request of the Superintendent, assisting the local
30 educational agency or consortium in planning and implementing
31 this program, including assisting with local technical assistance,
32 and developing agency collaboration.

33 *SEC. 2. Section 56475 of the Education Code is amended to*
34 *read:*

35 56475. (a) The Superintendent and the directors of the State
36 Department of Health Care Services, ~~the State Department of~~
37 ~~Mental Health,~~ the State Department of Developmental Services,
38 the State Department of Social Services, the Department of

1 Rehabilitation, the Department of Corrections and Rehabilitation,
2 Division of Juvenile Facilities, and the Employment Development
3 Department shall develop written interagency agreements or adopt
4 joint regulations that include responsibilities, in accordance with
5 Section 1412(a)(12) of Title 20 of the United States Code and
6 Section 300.154 of Title 34 of the Code of Federal Regulations,
7 for the provision of special education and related services to
8 individuals with exceptional needs in the State of California.

9 (b) The Superintendent shall develop interagency agreements
10 with other state and local public agencies, as deemed necessary
11 by the Superintendent, to carry out the provisions of state and
12 federal law.

13 (c) (1) Each interagency agreement shall be submitted by the
14 Superintendent to each legislative fiscal committee, education
15 committee, and policy committee, responsible for legislation
16 relating to those individuals with exceptional needs that will be
17 affected by the agreement if it is effective.

18 (2) An interagency agreement shall not be effective sooner than
19 30 days after it has been submitted to each of the legislative
20 committees specified in paragraph (1).

21 *SEC. 3. Section 12803.65 of the Government Code is amended*
22 *to read:*

23 12803.65. (a) The Governor shall rename and establish, in the
24 California Health and Human Services Agency, Department of
25 Rehabilitation, the existing “California Governor’s Committee on
26 Employment of People with Disabilities” as the “California
27 Committee on Employment of People with Disabilities.”

28 (b) (1) The California Committee on Employment of People
29 with Disabilities shall include, but not be limited to, the following:

30 (A) Four individuals with disabilities representing disabled
31 persons, one each appointed by the Senate Committee on Rules
32 and the Speaker of the Assembly and two appointed by the
33 Secretary of California Health and Human Services, each for a
34 three-year term.

35 (B) The Directors of the Employment Development Department,
36 State Department of Health Care Services, ~~State Department of~~
37 ~~Mental Health~~, State Department of Developmental Services, State
38 Department of Social Services, and Department of Rehabilitation,
39 and the Chair of the State Independent Living Council.

1 (C) A representative from the California Health Incentive
2 Improvement Project.

3 (D) A representative from the California Workforce Investment
4 Board who is nominated by that board.

5 (E) At the discretion of the Secretary of California Health and
6 Human Services, representatives from any other department or
7 program that may have a role in increasing the capacity of state
8 programs to support the employment-related needs of individuals
9 with disabilities.

10 (F) A representative from a local one-stop or local workforce
11 investment board, to be nominated by the California Workforce
12 Investment Board.

13 (G) Three business representatives with experience in employing
14 persons with disabilities, to be appointed by the Secretary of
15 California Health and Human Services.

16 (2) The members of the California Committee on Employment
17 of People with Disabilities shall select a chair from among the
18 members, and shall hold open meetings no less than four times a
19 year.

20 (c) The California Committee on Employment of People with
21 Disabilities shall consult with and advise the Labor and Workforce
22 Development Agency and the California Health and Human
23 Services Agency on all issues related to full inclusion in the
24 workforce of persons with disabilities, including development of
25 the comprehensive strategy required pursuant to Section 12803.6.

26 (d) The California Committee on Employment of People with
27 Disabilities shall coordinate and provide leadership, as necessary,
28 with regard to efforts to increase inclusion in the workforce of
29 persons with disabilities, including, but not limited to, one annual
30 event for youth with disabilities, to the extent funding is available.

31 (e) The California Committee on Employment of People with
32 Disabilities shall meet four times a year with the California Health
33 Incentive Improvement Project and the project's steering
34 committee, to the extent funding for the project continues and the
35 activities of the California Committee on Employment of People
36 with Disabilities are not inconsistent with the charge of the
37 California Health Incentive Improvement Project.

38 (f) Using existing funding, the California Committee on
39 Employment of People with Disabilities shall facilitate, promote,
40 and coordinate collaborative dissemination of information on

1 employment supports and benefits, which shall include the Ticket
2 to Work program and health benefits, to individuals with
3 disabilities, consumers of public services, employers, service
4 providers, and state and local agency staff.

5 (g) Using existing funding, the California Committee on
6 Employment of People with Disabilities shall receive primary
7 administrative and staff support from the Department of
8 Rehabilitation, subject to funding from the Employment
9 Development Department.

10 *SEC. 4. Section 95001 of the Government Code is amended to*
11 *read:*

12 95001. (a) The Legislature hereby finds and declares all of the
13 following:

14 (1) There is a need to provide appropriate early intervention
15 services individually designed for infants and toddlers from birth
16 to two years of age, inclusive, who have disabilities or are at risk
17 of having disabilities, to enhance their development and to
18 minimize the potential for developmental delays.

19 (2) Early intervention services for infants and toddlers with
20 disabilities or who are at risk of having disabilities represent an
21 investment of resources, in that these services reduce the ultimate
22 costs to our society, by minimizing the need for special education
23 and related services in later school years and by minimizing the
24 likelihood of institutionalization. These services also maximize
25 the ability of families to better provide for the special needs of
26 their children. Early intervention services for infants and toddlers
27 with disabilities maximize the potential of the individuals to be
28 effective in the context of daily life and activities, including the
29 potential to live independently, and exercise the full rights of
30 citizenship. The earlier intervention is started, the greater is the
31 ultimate cost-effectiveness and the higher is the educational
32 attainment and quality of life achieved by children with disabilities.

33 (3) The family is the constant in the child's life, while the service
34 system and personnel within those systems fluctuate. Because the
35 primary responsibility of an infant's or toddler's well-being rests
36 with the family, services should support and enhance the family's
37 capability to meet the special developmental needs of their infant
38 or toddler with disabilities.

1 (4) Family-to-family support strengthens families' ability to
2 fully participate in services planning and their capacity to care for
3 their infants or toddlers with disabilities.

4 (5) Meeting the complex needs of infants with disabilities and
5 their families requires active state and local coordinated,
6 collaborative, and accessible service delivery systems that are
7 flexible, culturally competent, and responsive to family-identified
8 needs. When health, developmental, educational, and social
9 programs are coordinated, they are proven to be cost effective, not
10 only for systems, but for families as well.

11 (6) Family-professional collaboration contributes to changing
12 the ways that early intervention services are provided and to
13 enhancing their effectiveness.

14 (7) Infants and toddlers with disabilities are a part of their
15 communities, and as citizens make valuable contributions to society
16 as a whole.

17 (b) Therefore, it is the intent of the Legislature that:

18 (1) Funding provided under Part C of the federal Individuals
19 with Disabilities Education Act (20 U.S.C. Sec. 1431 et seq.) be
20 used to improve and enhance early intervention services as defined
21 in this title by developing innovative ways of providing family
22 focused, coordinated services, which are built upon existing
23 systems.

24 (2) The State Department of Developmental Services, the State
25 Department of Education, the State Department of Health Care
26 Services, ~~the State Department of Mental Health~~, the State
27 Department of Social Services, and the State Department of
28 Alcohol and Drug Programs coordinate services to infants and
29 toddlers with disabilities and their families. These agencies need
30 to collaborate with families and communities to provide a
31 family-centered, comprehensive, multidisciplinary, interagency,
32 community-based, early intervention system for infants and
33 toddlers with disabilities.

34 (3) Families be well informed, supported, and respected as
35 capable and collaborative decisionmakers regarding services for
36 their child.

37 (4) Professionals be supported to enhance their training and
38 maintain a high level of expertise in their field, as well as
39 knowledge of what constitutes most effective early intervention
40 practices.

1 (5) Families and professionals join in collaborative partnerships
2 to develop early intervention services that meet the needs of infants
3 and toddlers with disabilities, and that those partnerships be the
4 basis for the development of services that meet the needs of the
5 culturally and linguistically diverse population of California.

6 (6) To the maximum extent possible, infants and toddlers with
7 disabilities and their families be provided services in the most
8 natural environment, and include the use of natural supports and
9 existing community resources.

10 (7) The services delivery system be responsive to the families
11 and children it serves within the context of cooperation and
12 coordination among the various agencies.

13 (8) Early intervention program quality be ensured and
14 maintained through established early intervention program and
15 personnel standards.

16 (9) The early intervention system be responsive to public input
17 and participation in the development of implementation policies
18 and procedures for early intervention services through the forum
19 of an interagency coordinating council established pursuant to
20 federal regulations under Part C of the federal Individuals with
21 Disabilities Education Act.

22 (c) It is not the intent of the Legislature to require the State
23 Department of Education to implement this title unless adequate
24 reimbursement, as specified and agreed to by the department, is
25 provided to the department from federal funds from Part C of the
26 federal Individuals with Disabilities Education Act.

27 *SEC. 5. Section 95003 of the Government Code, as added by*
28 *Section 4 of Chapter 945 of the Statutes of 1993, is amended to*
29 *read:*

30 95003. It is the intent of the Legislature that the State
31 Department of Health Care Services, the State Department of
32 Developmental Services, ~~the State Department of Mental Health,~~
33 the State Department of Social Services, and the State Department
34 of Education work together to provide coordinated, interagency
35 services to high-risk and disabled infants and their families.

36 *SEC. 6. Section 95012 of the Government Code is amended to*
37 *read:*

38 95012. (a) The following departments shall cooperate and
39 coordinate their early intervention services for eligible infants and
40 their families under this title, and need to collaborate with families

1 and communities, to provide a family-centered, comprehensive,
2 multidisciplinary, interagency, community-based early intervention
3 system:

4 (1) State Department of Developmental Services.

5 (2) State Department of Education.

6 (3) State Department of Health *Care* Services.

7 (4) State Department of Social Services.

8 ~~(5) State Department of Mental Health.~~

9 ~~(6)~~

10 (5) State Department of Alcohol and Drug Programs.

11 (b) Each participating department shall enter into an interagency
12 agreement with the State Department of Developmental Services.
13 Each interagency agreement shall specify, at a minimum, the
14 agency's current and continuing level of financial participation in
15 providing services to infants and toddlers with disabilities and their
16 families. Each interagency agreement shall also specify procedures
17 for resolving disputes in a timely manner. Interagency agreements
18 shall also contain provisions for ensuring effective cooperation
19 and coordination among agencies concerning policymaking
20 activities associated with the implementation of this title, including
21 legislative proposals, regulation development, and fiscal planning.
22 All interagency agreements shall be reviewed annually and revised
23 as necessary.

24 *SEC. 7. Section 95020 of the Government Code is amended to*
25 *read:*

26 95020. (a) An eligible infant or toddler shall have an
27 individualized family service plan. The individualized family
28 service plan shall be used in place of an individualized education
29 program required pursuant to Sections 4646 and 4646.5 of the
30 Welfare and Institutions Code, the individualized program plan
31 required pursuant to Section 56340 of the Education Code, or any
32 other applicable service plan.

33 (b) For an infant or toddler who has been evaluated for the first
34 time, a meeting to share the results of the evaluation, to determine
35 eligibility and, for children who are eligible, to develop the initial
36 individualized family service plan shall be conducted within 45
37 calendar days of receipt of the written referral. Evaluation results
38 and determination of eligibility may be shared in a meeting with
39 the family prior to the individualized family service plan. Written
40 parent consent to evaluate and assess shall be obtained within the

1 45-day timeline. A regional center, local educational agency, or
2 the designee of one of those entities shall initiate and conduct this
3 meeting. Families shall be afforded the opportunity to participate
4 in all decisions regarding eligibility and services. During intake
5 and assessment, but no later than the IFSP meeting, the parents,
6 legal guardian, or conservator shall provide copies of any health
7 benefit cards under which the consumer is eligible to receive health
8 benefits, including, but not limited to, private health insurance, a
9 health care service plan, Medi-Cal, Medicare, and TRICARE. If
10 the individual, or, where appropriate, the parents, legal guardians,
11 or conservators, have no such benefits, the regional center shall
12 not use that fact to negatively impact the services that the individual
13 may or may not receive from the regional center.

14 (c) Parents shall be fully informed of their rights, including the
15 right to invite another person, including a family member or an
16 advocate or peer parent, or any or all of them, to accompany them
17 to any or all individualized family service plan meetings. With
18 parental consent, a referral shall be made to the local family
19 resource center or network.

20 (d) The individualized family service plan shall be in writing
21 and shall address all of the following:

22 (1) A statement of the infant's or toddler's present levels of
23 physical development including vision, hearing, and health status,
24 cognitive development, communication development, social and
25 emotional development, and adaptive developments.

26 (2) With the concurrence of the family, a statement of the
27 family's concerns, priorities, and resources related to meeting the
28 special developmental needs of the eligible infant or toddler.

29 (3) A statement of the major outcomes expected to be achieved
30 for the infant or toddler and family where services for the family
31 are related to meeting the special developmental needs of the
32 eligible infant or toddler.

33 (4) The criteria, procedures, and timelines used to determine
34 the degree to which progress toward achieving the outcomes is
35 being made and whether modifications or revisions are necessary.

36 (5) (A) A statement of the specific early intervention services
37 necessary to meet the unique needs of the infant or toddler as
38 identified in paragraph (3), including, but not limited to, the
39 frequency, intensity, location, duration, and method of delivering
40 the services, and ways of providing services in natural generic

1 environments, including group training for parents on behavioral
2 intervention techniques in lieu of some or all of the in-home parent
3 training component of the behavior intervention services, and
4 purchase of neighborhood preschool services and needed qualified
5 personnel in lieu of infant development programs.

6 (B) Effective July 1, 2009, at the time of development, review,
7 or modification of an infant's or toddler's individualized family
8 service plan, the regional center shall consider both of the
9 following:

10 (i) The use of group training for parents on behavior intervention
11 techniques, in lieu of some or all of the in-home parent training
12 component of the behavior intervention services.

13 (ii) The purchase of neighborhood preschool services and needed
14 qualified personnel, in lieu of infant development programs.

15 (6) A statement of the agency responsible for providing the
16 identified services.

17 (7) The name of the service coordinator who shall be responsible
18 for facilitating implementation of the plan and coordinating with
19 other agencies and persons.

20 (8) The steps to be taken to ensure transition of the infant or
21 toddler upon reaching three years of age to other appropriate
22 services. These may include, as appropriate, special education or
23 other services offered in natural environments.

24 (9) The projected dates for the initiation of services in paragraph
25 (5) and the anticipated duration of those services.

26 (e) Each service identified on the individualized family service
27 plan shall be designated as one of three types:

28 (1) An early intervention service, as defined in subsection (4)
29 of Section 1432 of Title 20 of the United States Code, and
30 applicable regulations, that is provided or purchased through the
31 regional center, local educational agency, or other participating
32 agency. The State Department of Health Care Services, State
33 Department of Social Services, ~~State Department of Mental Health,~~
34 and State Department of Alcohol and Drug Programs shall provide
35 services in accordance with state and federal law and applicable
36 regulations, and up to the level of funding as appropriated by the
37 Legislature. Early intervention services identified on an
38 individualized family service plan that exceed the funding,
39 statutory, and regulatory requirements of these departments shall
40 be provided or purchased by regional centers or local educational

1 agencies under subdivisions (b) and (c) of Section 95014. The
2 State Department of Health Care Services, State Department of
3 Social Services, ~~State Department of Mental Health~~, and State
4 Department of Alcohol and Drug Programs shall not be required
5 to provide early intervention services over their existing funding,
6 statutory, and regulatory requirements.

7 (2) Another service, other than those specified in paragraph (1),
8 which the eligible infant or toddler or his or her family may receive
9 from other state programs, subject to the eligibility standards of
10 those programs.

11 (3) A referral to a nonrequired service that may be provided to
12 an eligible infant or toddler or his or her family. Nonrequired
13 services are those services that are not defined as early intervention
14 services or do not relate to meeting the special developmental
15 needs of an eligible infant or toddler related to the disability, but
16 that may be helpful to the family. The granting or denial of
17 nonrequired services by a public or private agency is not subject
18 to appeal under this title. Notwithstanding any other provision of
19 law or regulation to the contrary, effective July 1, 2009, with the
20 exception of durable medical equipment, regional centers shall not
21 purchase nonrequired services, but may refer a family to a
22 nonrequired service that may be available to an eligible infant or
23 toddler or his or her family.

24 (f) An annual review, and other periodic reviews, of the
25 individualized family service plan for an infant or toddler and the
26 infant's or toddler's family shall be conducted to determine the
27 degree of progress that is being made in achieving the outcomes
28 specified in the plan and whether modification or revision of the
29 outcomes or services is necessary. The frequency, participants,
30 purpose, and required processes for annual and periodic reviews
31 shall be consistent with the statutes and regulations under Part C
32 of the federal Individuals with Disabilities Education Act (20
33 U.S.C. Sec. 1431 et seq.) and this title, and shall be specified in
34 regulations adopted pursuant to Section 95028. At the time of the
35 review, the parents, legal guardian, or conservator shall provide
36 copies of any health benefit cards under which the consumer is
37 eligible to receive health benefits, including, but not limited to,
38 private health insurance, a health care service plan, Medi-Cal,
39 Medicare, and TRICARE. If the parents, legal guardian, or
40 conservator have no such benefit cards, the regional center shall

1 not use that fact to negatively impact the services that the individual
2 may or may not receive from the regional center.

3 *SEC. 8. Section 124174.2 of the Health and Safety Code is*
4 *amended to read:*

5 124174.2. (a) The department, in cooperation with the State
6 Department of Education, shall establish a Public School Health
7 Center Support Program.

8 (b) The program, in collaboration with the State Department of
9 Education, shall perform the following program functions:

10 (1) Provide technical assistance to school health centers on
11 effective outreach and enrollment strategies to identify children
12 who are eligible for, but not enrolled in, the Medi-Cal program,
13 the Healthy Families Program, or any other applicable program.

14 (2) Serve as a liaison between organizations within the
15 department, including, but not limited to, prevention services,
16 primary care, and family health.

17 (3) Serve as a liaison between other state entities, as appropriate,
18 including, but not limited to, the State Department of Health Care
19 Services, ~~the State Department of Mental Health~~, the State
20 Department of Alcohol and Drug Programs, the Department of
21 Managed Health Care, the California Emergency Management
22 Agency, and the Managed Risk Medical Insurance Board.

23 (4) Provide technical assistance to facilitate and encourage the
24 establishment, retention, or expansion of, school health centers.
25 For purposes of this paragraph, technical assistance may include,
26 but is not limited to, identifying available public and private
27 sources of funding, which may include federal Medicaid funds,
28 funds from third-party reimbursements, and available federal or
29 foundation grant moneys.

30 (c) The department shall consult with interested parties and
31 appropriate stakeholders, including the California School Health
32 Centers Association and representatives of youth and parents, in
33 carrying out its responsibilities under this article.

34 *SEC. 9. Section 4510 of the Welfare and Institutions Code is*
35 *amended to read:*

36 4510. The State Department of Developmental Services ~~and,~~
37 ~~the State Department of Mental Health Care Services, and the~~
38 ~~State Department of State Hospitals~~ shall jointly develop and
39 implement a statewide program for encouraging the establishment
40 of sufficient numbers and types of living arrangements, both in

1 communities and state hospitals, as necessary to meet the needs
2 of persons served by those departments. The departments shall
3 consult with the following organizations in the development of
4 procedures pursuant to this section:

5 (a) The League of California Cities, the County Supervisors
6 Association of California, and representatives of other local
7 agencies.

8 (b) Organizations or advocates for clients receiving services in
9 residential care services.

10 (c) Providers of residential care services.

11 *SEC. 10. Section 5213 of the Welfare and Institutions Code is*
12 *amended to read:*

13 5213. (a) If, upon evaluation, the person is found to be in need
14 of treatment because he or she is, as a result of mental disorder, a
15 danger to others, or to himself or herself, or is gravely disabled,
16 he or she may be detained for treatment in a facility for 72-hour
17 treatment and evaluation. Saturdays, Sundays, and holidays may
18 be excluded from the 72-hour period if the State Department of
19 ~~Mental Health~~ *Social Services* certifies for each facility that
20 evaluation and treatment services cannot reasonably be made
21 available on those days. The certification by the department is
22 subject to renewal every two years. The department shall adopt
23 regulations defining criteria for determining whether a facility can
24 reasonably be expected to make evaluation and treatment services
25 available on Saturdays, Sundays, and holidays.

26 (b) Persons who have been detained for evaluation and
27 treatment, who are receiving medications as a result of their mental
28 illness, shall be given, as soon as possible after detention, written
29 and oral information about the probable effects and possible side
30 effects of the medication, by a person designated by the mental
31 health facility where the person is detained. The State Department
32 of ~~Mental Health~~ *Social Services* shall develop and promulgate
33 written materials on the effects of medications, for use by county
34 mental health programs as disseminated or as modified by the
35 county mental health program, addressing the probable effects and
36 the possible side effects of the medication. The following
37 information shall be given orally to the patient:

38 (1) The nature of the mental illness, or behavior, that is the
39 reason the medication is being given or recommended.

1 (2) The likelihood of improving or not improving without the
2 medications.

3 (3) Reasonable alternative treatments available.

4 (4) The name and type, frequency, amount, and method of
5 dispensing the medications, and the probable length of time that
6 the medications will be taken.

7 The fact that the information has or has not been given shall be
8 indicated in the patient's chart. If the information has not been
9 given, the designated person shall document in the patient's chart
10 the justification for not providing the information. A failure to give
11 information about the probable effects and possible side effects of
12 the medication shall not constitute new grounds for release.

13 *SEC. 11. Section 5256.1 of the Welfare and Institutions Code*
14 *is amended to read:*

15 5256.1. The certification review hearing shall be conducted
16 by either a court-appointed commissioner or a referee, or a
17 certification review hearing officer. The certification review
18 hearing officer shall be either a state qualified administrative law
19 hearing officer, a physician and surgeon, a licensed psychologist,
20 a registered nurse, a lawyer, a certified law student, a licensed
21 clinical social worker, a licensed marriage and family therapist,
22 or a licensed professional clinical counselor. Licensed
23 psychologists, licensed clinical social workers, licensed marriage
24 and family therapists, licensed professional clinical counselors,
25 and registered nurses who serve as certification review hearing
26 officers shall have had a minimum of five years' experience in
27 mental health. Certification review hearing officers shall be selected
28 from a list of eligible persons unanimously approved by a panel
29 composed of the local mental health director, the county public
30 defender, and the county counsel or district attorney designated
31 by the county board of supervisors. No employee of the county
32 mental health program or of any facility designated by the county
33 and approved by the State Department of ~~Mental Health~~ *Social*
34 *Services* as a facility for 72-hour treatment and evaluation may
35 serve as a certification review hearing officer.

36 The location of the certification review hearing shall be
37 compatible with, and least disruptive of, the treatment being
38 provided to the person certified. In addition, hearings conducted
39 by certification review officers shall be conducted at an appropriate

1 place at the facility where the person certified is receiving
2 treatment.

3 *SEC. 12. Section 5875 of the Welfare and Institutions Code is*
4 *amended to read:*

5 5875. The Secretary of *California Health and Welfare Human*
6 *Services* shall require the State Department of ~~Mental Health Care~~
7 *Services* to develop an administrative waiver process for counties
8 that either propose to be, or are considered, system of care counties
9 by the department.

10 *SEC. 13. Section 14005.26 of the Welfare and Institutions*
11 *Code, as added by Section 10 of Chapter 28 of the Statutes of 2012,*
12 *is amended to read:*

13 14005.26. (a) The department shall exercise the option
14 pursuant to Section 1902(a)(10)(A)(ii)(XIV) of the federal Social
15 Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide
16 full-scope benefits with no share of cost under this chapter and
17 Chapter 8 (commencing with Section 14200) to ~~children who have~~
18 ~~attained six years of age but have not attained 19 years of age, who~~
19 ~~are~~ optional targeted low-income children pursuant to Section
20 1905(u)(2)(B) of the federal Social Security Act (42 U.S.C. Sec.
21 1396d(u)(2)(B)), with family incomes up to and including 200
22 percent of the federal poverty level. The department shall seek
23 federal approval of a state plan amendment to implement this
24 subdivision.

25 (b) Pursuant to Section 1902(r)(2) of the federal Social Security
26 Act (42 U.S.C. Sec. 1396a(r)(2)), the department shall adopt the
27 option to use less restrictive income and resource methodologies
28 to exempt all resources and disregard income at or above 200
29 percent and up to and including 250 percent of the federal poverty
30 level for the individuals described in subdivision (a). The
31 department shall seek federal approval of a state plan amendment
32 to implement this subdivision.

33 (c) For purposes of carrying out the provisions of this section,
34 the department may adopt the option pursuant to Section
35 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec.
36 1396a(e)(13)) to rely upon findings of the Managed Risk Medical
37 Insurance Board (MRMIB) regarding one or more components of
38 eligibility.

39 (d) (1) The department shall exercise the option pursuant to
40 Section 1916A of the federal Social Security Act (42 U.S.C. Sec.

1396o-1) to impose premiums for individuals described in subdivision (a) whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to subdivision (b). The department shall not impose premiums under this subdivision for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the income disregard pursuant to subdivision (b). The department shall obtain federal approval for the implementation of this subdivision.

(2) ~~All~~ (A) Monthly premiums imposed under this section shall equal the family contributions described in paragraph (2) of subdivision (d) of Section 12693.43 of the Insurance Code and shall be reduced in conformity with subdivisions (e) and (f) of Section 12693.43 of the Insurance Code *thirteen dollars (\$13) per child with a maximum contribution of thirty-nine dollars (\$39) per family.*

(B) Families that pay three months of required premiums in advance shall receive the fourth consecutive month of coverage with no premium required. For purposes of the discount provided by this subparagraph, family contributions paid in the Healthy Families Program for children transitioned to Medi-Cal pursuant to Section 14005.27 shall be credited as Medi-Cal premiums paid.

(C) Families that pay the required premium by an approved means of electronic funds transfer, including credit card payment, shall receive a 25 percent discount from the required premium. If the department and the Managed Risk Medical Insurance Board determine that it is feasible, the department shall treat an authorization for electronic funds transfer or credit card payment to the Healthy Families Program as an authorization for electronic funds transfer or credit card payment to Medi-Cal.

(e) This section shall be implemented only to the extent that all necessary federal approvals and waivers described in this section have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(f) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all

1 necessary federal approvals and waivers have been obtained, and
2 no sooner than January 1, 2013.

3 (g) (1) To the extent the new budget methodology pursuant to
4 paragraph (6) of subdivision (a) of Section 14154 is not fully
5 operational, for the purposes of implementing this section, for
6 individuals described in subdivision (a) whose family income has
7 been determined to be up to and including 150 percent of the
8 federal poverty level, as determined pursuant to subdivision (b),
9 the department shall utilize the budgeting methodology for this
10 population as contained in the November 2011 Medi-Cal Local
11 Assistance Estimate for Medi-Cal county administration costs for
12 eligibility operations.

13 (2) For purposes of implementing this section, the department
14 shall include in the Medi-Cal Local Assistance Estimate an amount
15 for Medi-Cal eligibility operations associated with the individuals
16 whose family income is determined to be above 150 percent and
17 up to and including 200 percent of the federal poverty level, after
18 application of the income disregard pursuant to subdivision (b).
19 In developing an estimate for this activity, the department shall
20 consider the projected number of final eligibility determinations
21 each county will process and projected county costs. Within 60
22 days of the passage of the annual Budget Act, the department shall
23 notify each county of their allocation for this activity based upon
24 the amount allotted in the annual Budget Act for this purpose.

25 (h) When the new budget methodology pursuant to paragraph
26 (6) of subdivision (a) of Section 14154 is fully operational, the
27 new budget methodology shall be utilized to reimburse counties
28 for eligibility determinations made for individuals pursuant to this
29 section.

30 (i) Eligibility determinations and annual redeterminations made
31 pursuant to this section shall be performed by county eligibility
32 workers.

33 (j) In conducting eligibility determinations for individuals
34 pursuant to this section and Section 14005.27, the following
35 reporting and performance standards shall apply to all counties:

36 (1) Counties shall report to the department, in a manner and for
37 a time period prescribed by the department, in consultation with
38 the County Welfare Directors Association, the number of
39 applications processed on a monthly basis, a breakout of the
40 applications based on income using the federal percentage of

1 poverty levels, the final disposition of each application, including
2 information on the approved Medi-Cal program, if applicable, and
3 the average number of days it took to make the final eligibility
4 determination for applications submitted directly to the county and
5 from the single point of entry (SPE).

6 (2) Notwithstanding any other provision of law, the following
7 performance standards shall be applied to counties regarding
8 eligibility determinations for individuals eligible pursuant to this
9 section:

10 (A) For children whose applications are received by the county
11 human services department from the SPE, the following standards
12 shall apply:

13 (i) Applications for children who are granted accelerated
14 enrollment by the SPE shall be processed according to the
15 timeframes specified in subdivision (d) of Section 14154.

16 (ii) Applications for children who are not granted accelerated
17 enrollment by the SPE due to the existence of an already active
18 Medi-Cal case shall be processed according to the timeframes
19 specified in subdivision (d) of Section 14154.

20 (iii) For applications for children who are not described in clause
21 (i) or (ii), 90 percent shall be processed within 10 working days
22 of being received, complete and without client errors.

23 (iv) If an application described in this section also contains
24 adults, and the adult applicants are required to submit additional
25 information beyond the information provided for the children, the
26 county shall process the eligibility for the child or children without
27 delay, consistent with this section while gathering the necessary
28 information to process eligibility for the adults.

29 (B) The department, in consultation with the County Welfare
30 Directors Association, shall develop reporting requirements for
31 the counties to provide regular data to the state regarding the
32 timeliness and outcomes of applications processed by the counties
33 that are received from the SPE.

34 (C) Performance thresholds and corrective action standards as
35 set forth in Section 14154 shall apply.

36 (D) For applications submitted directly to the county, these
37 applications shall be processed by the counties in accordance with
38 the performance standards established under subdivision (d) of
39 Section 14154.

1 (3) This subdivision shall be implemented ~~90 days after the~~
2 ~~effective date of the act that added this section, or October 1, 2012,~~
3 ~~whichever is later~~ *no sooner than January 1, 2013.*

4 (4) Twelve months after implementation of this section pursuant
5 to subdivision (f), the department shall provide enrollment
6 information regarding individuals determined eligible pursuant to
7 subdivision (a) to the fiscal and appropriate policy committees of
8 the Legislature.

9 (k) (1) Notwithstanding Chapter 3.5 (commencing with Section
10 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
11 for purposes of this transition, the department, without taking any
12 further regulatory action, shall implement, interpret, or make
13 specific this section by means of all-county letters, plan letters,
14 plan or provider bulletins, or similar instructions until the time
15 regulations are adopted. It is the intent of the Legislature that the
16 department be allowed temporary authority as necessary to
17 implement program changes until completion of the regulatory
18 process.

19 (2) To the extent otherwise required by Chapter 3.5
20 (commencing with Section 11340) of Part 1 of Division 3 of Title
21 2 of the Government Code, the department shall adopt emergency
22 regulations implementing this section no later than July 1, 2014.
23 The department may thereafter readopt the emergency regulations
24 pursuant to that chapter. The adoption and readoption, by the
25 department, of regulations implementing this section shall be
26 deemed to be an emergency and necessary to avoid serious harm
27 to the public peace, health, safety, or general welfare for purposes
28 of Sections 11346.1 and 11349.6 of the Government Code, and
29 the department is hereby exempted from the requirement that it
30 describe facts showing the need for immediate action and from
31 review by the Office of Administrative Law.

32 *(l) To implement this section, the department may enter into*
33 *and continue contracts with the Healthy Families Program*
34 *administrative vendor, for the purposes of implementing and*
35 *maintaining the necessary systems and activities for providing*
36 *health care coverage to optional targeted low-income children in*
37 *the Medi-Cal program for purposes of accelerated enrollment*
38 *application processing by single point of entry,*
39 *noneligibility-related case maintenance and premium collection,*
40 *maintenance of the Health-E-App Web portal, call center staffing*

and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(f)

(m) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof, in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of the State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's Internet Web site.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 14. Section 14005.27 of the Welfare and Institutions Code, as added by Section 11 of Chapter 28 of the Statutes of 2012, is amended to read:

1 14005.27. (a) Individuals enrolled in the Healthy Families
2 Program pursuant to Part 6.2 (commencing with Section 12693)
3 of Division 2 of the Insurance Code on the effective date of the
4 act that added this section and who are determined eligible to
5 receive benefits pursuant to subdivisions (a) and (b) of Section
6 14005.26, shall be transitioned into Medi-Cal, pursuant to this
7 section.

8 (b) To the extent necessary and for the purposes of carrying out
9 the provisions of this section, in performing initial eligibility
10 determinations for children enrolled in the Healthy Families
11 Program pursuant to Part 6.2 (commencing with Section 12693)
12 of Division 2 of the Insurance Code, the department shall adopt
13 the option pursuant to Section 1902(e)(13) of the federal Social
14 Security Act (42 U.S.C. Sec. 1396a(e)(13)) to allow the department
15 or county human services departments to rely upon findings made
16 by the Managed Risk Medical Insurance Board (MRMIB)
17 regarding one or more components of eligibility. The department
18 shall seek federal approval of a state plan amendment to implement
19 this subdivision.

20 (c) To the extent necessary, the department shall seek federal
21 approval of a state plan amendment or a waiver to provide
22 presumptive eligibility for the optional targeted low-income
23 category of eligibility pursuant to Section 14005.26 for individuals
24 presumptively eligible for or enrolled in the Healthy Families
25 Program pursuant to Part 6.2 (commencing with Section 12693)
26 of Division 2 of the Insurance Code. The presumptive eligibility
27 shall be based upon the most recent information contained in the
28 individual's Healthy Families Program file. The timeframe for the
29 presumptive eligibility shall begin no sooner than January 1, 2013,
30 and shall continue until a determination of Medi-Cal eligibility is
31 made, which determination shall be performed within one year of
32 the individual's Healthy Families Program annual review date.

33 (d) (1) The California Health and Human Services Agency, in
34 consultation with the Managed Risk Medical Insurance Board, the
35 State Department of Health Care Services, the Department of
36 Managed Health Care, and diverse stakeholders groups, shall
37 provide the fiscal and policy committees of the Legislature with
38 a strategic plan for the transition of the Healthy Families Program
39 pursuant to this section by no later than October 1, 2012. This
40 strategic plan shall, at a minimum, address all of the following:

1 (A) State, county, and local administrative components which
2 facilitate a successful subscriber transition such as communication
3 and outreach to subscribers and applicants, eligibility processing,
4 enrollment, communication, and linkage with health plan providers,
5 payments of applicable premiums, and overall systems operation
6 functions.

7 (B) Methods and processes for diverse stakeholder engagement
8 throughout the entire transition, including all phases of the
9 transition.

10 (C) State monitoring of managed care health plans' performance
11 and accountability for provision of services, and initial quality
12 indicators for children and adolescents transitioning to Medi-Cal.

13 (D) Health care and dental delivery system components such
14 as standards for informing and enrollment materials, network
15 adequacy, performance measures and metrics, fiscal solvency, and
16 related factors that ensure timely access to quality health and dental
17 care for children and adolescents transitioning to Medi-Cal.

18 (E) Inclusion of applicable operational steps, timelines, and key
19 milestones.

20 (F) A time certain for the transfer of the Healthy Families
21 Advisory Board, as described in Part 6.2 (commencing with Section
22 12693) of Division 2 of the Insurance Code, to the State
23 Department of Health Care Services.

24 (2) The intent of this strategic plan is to serve as an overall guide
25 for the development of each plan for each phase of this transition,
26 pursuant to paragraphs (1) to (8), inclusive, of subdivision (e), to
27 ensure clarity and consistency in approach and subscriber
28 continuity of care. This strategic plan may also be updated by the
29 California Health and Human Services Agency as applicable and
30 provided to the Legislature upon completion.

31 (e) (1) The department shall transition individuals from the
32 Healthy Families Program to the Medi-Cal program in four phases,
33 as follows:

34 (A) Phase 1. Individuals enrolled in a Healthy Families Program
35 health plan that is a Medi-Cal managed care health plan shall be
36 enrolled in the same plan no earlier than January 1, 2013, pursuant
37 to the requirements of this section and Section 14011.6, and to the
38 extent the individual is otherwise eligible under this chapter and
39 Chapter 8 (commencing with Section 14200).

1 (B) Phase 2. Individuals enrolled in a Healthy Families Program
2 managed care health plan that is a subcontractor of a Medi-Cal
3 managed health care plan, to the extent possible, shall be enrolled
4 into a Medi-Cal managed health care plan that includes the
5 individuals' current plan pursuant to the requirements of this
6 section and Section 14011.6, and to the extent the individuals are
7 otherwise eligible under this chapter and Chapter 8 (commencing
8 with Section 14200). The transition of individuals described in
9 this subparagraph shall begin no earlier than April 1, 2013.

10 (C) Phase 3. Individuals enrolled in a Healthy Families Program
11 plan that is not a Medi-Cal managed care plan and does not contract
12 or subcontract with a Medi-Cal managed care plan shall be enrolled
13 in a Medi-Cal managed care plan in that county. Enrollment shall
14 include consideration of the individuals' primary care providers
15 pursuant to the requirements of this section and Section 14011.6,
16 and to the extent the individuals are otherwise eligible under this
17 chapter and Chapter 8 (commencing with Section 14200). The
18 transition of individuals described in this subparagraph shall begin
19 no earlier than August 1, 2013.

20 (D) Phase 4.

21 (i) Individuals residing in a county that is not a Medi-Cal
22 managed care county shall be provided services under the Medi-Cal
23 fee-for-service delivery system, subject to clause (ii). The transition
24 of individuals described in this subparagraph shall begin no earlier
25 than September 1, 2013.

26 (ii) In the event the department creates a managed health care
27 system in the counties described in clause (i), individuals residing
28 in those counties shall be enrolled in managed health care plans
29 pursuant to this chapter and Chapter 8 (commencing with Section
30 14200).

31 (2) For the transition of individuals pursuant to subparagraphs
32 (A), (B), (C), and (D) of paragraph (1), implementation plans shall
33 be developed to ensure state and county systems readiness, health
34 plan network adequacy, and continuity of care with the goal of
35 ensuring there is no disruption of service and there is continued
36 access to coverage for all transitioning individuals. If an individual
37 is not retained with his or her current primary care provider, the
38 implementation plan shall require the managed care plan to report
39 to the department as to how continuity of care is being provided.
40 Transition of individuals described in subparagraphs (A), (B), (C),

and (D) of paragraph (1) shall not occur until 90 days after the department has submitted an implementation plan to the fiscal and policy committees of the Legislature. The implementation plans shall include, but not be limited to, information on health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

(3) The following requirements shall be in place prior to implementation of Phase 1, and shall be required for all phases of the transition:

(A) Managed care plan performance measures shall be integrated and coordinated with the Healthy Families Program performance standards including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. These performance measures shall also be in compliance with all performance 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) and existing Medi-Cal managed care performance measurements and standards as set forth in this chapter and Chapter 8 (commencing with Section 14200), Title 22 of the California Code of Regulations, and all-plan letters, including, but not limited to, network adequacy and linguistic services, and shall be met prior to the transition of individuals pursuant to Phase 1.

(B) Medi-Cal managed care health plans shall allow enrollees to remain with their current primary care provider. If an individual does not remain with the current primary care provider, the plan shall report to the department as to how continuity of care is being provided.

(4) (A) As individuals are transitioned pursuant to subparagraphs (A) and (B), (B), (C), and (D) of paragraph (1), for individuals residing in all counties except the Counties of Sacramento and Los Angeles, their dental coverage shall transition to fee-for-service dental coverage and may be provided by their current provider if the provider is a Medi-Cal fee-for-service dental provider.

(B) For individuals residing in the County of Sacramento, their dental coverage shall continue to be provided by their current dental managed care plan if their plan is a Medi-Cal dental

1 managed care plan. If their plan is not a Medi-Cal dental managed
2 care plan, they shall select a Medi-Cal dental managed care plan.
3 If they do not choose a Medi-Cal dental managed care plan, they
4 shall be assigned to a plan with preference to a plan with which
5 their current provider is a contracted provider. Any children in the
6 Healthy Families Program transitioned into Medi-Cal dental
7 managed care plans shall also have access to the beneficiary dental
8 exception process, pursuant to Section 14089.09. Further, the
9 Sacramento advisory committee, established pursuant to Section
10 14089.08, shall be consulted regarding the transition of children
11 in the Healthy Families Program into Medi-Cal dental managed
12 care plans.

13 (C) (i) For individuals residing in the County of Los Angeles,
14 for purposes of continuity of care, their dental coverage shall
15 continue to be provided by their current dental managed care plan
16 if that plan is a Medi-Cal dental managed care plan. If their plan
17 is not a Medi-Cal dental managed care plan, they may select a
18 Medi-Cal dental managed care plan or choose to move into
19 Medi-Cal fee-for-service dental coverage.

20 (ii) It is the intent of the Legislature that children transitioning
21 to Medi-Cal under this section have a choice in dental coverage,
22 as provided under existing law.

23 (5) Dental health plan performance measures and benchmarks
24 shall be in accordance with Section 14459.6.

25 (6) Medi-Cal managed care health and dental plans shall report
26 to the department, as frequently as specified by the department,
27 specified information pertaining to transition implementation,
28 enrollees, and providers, including, but not limited to, grievances
29 related to access to care, continuity of care requests and outcomes,
30 and changes to provider networks, including provider enrollment
31 and disenrollment changes. The plans shall report this information
32 by county, and in the format requested by the department.

33 (7) The department may develop supplemental implementation
34 plans to separately account for the transition of individuals from
35 the Healthy Families Program to specific Medi-Cal delivery
36 systems.

37 (8) The department shall consult with the Legislature and
38 stakeholders, including, but not limited to, consumers, families,
39 consumer advocates, counties, providers, and health and dental
40 plans, in the development of implementation plans described in

1 paragraph (3) for individuals who are transitioned to Medi-Cal in
2 Phase 2 ~~and~~, Phase 3, *and Phase 4*, as described in subparagraphs
3 (B) ~~and (C)~~, (C), *and (D)* of paragraph (1).

4 (9) (A) The department shall consult and collaborate with the
5 Department of Managed Health Care in assessing Medi-Cal
6 managed care health plan network adequacy in accordance with
7 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
8 2.2 (commencing with Section 1340) of Division 2 of the Health
9 and Safety Code) for purposes of the developed transition plans
10 pursuant to paragraph (2) for each of the phases.

11 (B) For purposes of individuals transitioning in Phase 1, as
12 described in subparagraph (A) of paragraph (1), network adequacy
13 shall be assessed as described in this paragraph and findings from
14 this assessment shall be provided to the fiscal and appropriate
15 policy committees of the Legislature 60 days prior to the effective
16 date of implementing this transition.

17 (10) The department shall provide monthly status reports to the
18 fiscal and policy committees of the Legislature on the transition
19 commencing no later than February 15, 2013. This monthly status
20 transition report shall include, but not be limited to, information
21 on health plan grievances related to access to care, continuity of
22 care requests and outcomes, changes to provider networks,
23 including provider enrollment and disenrollment changes, and
24 eligibility performance standards pursuant to subdivision (m). A
25 final comprehensive report shall be provided within 90 days after
26 completion of the last phase of transition.

27 (f) (1) The department and MRMIB shall work collaboratively
28 in the development of notices for individuals transitioned pursuant
29 to paragraph (1) of subdivision ~~(d)~~ (e).

30 (2) The state shall provide written notice to individuals enrolled
31 in the Healthy Families Program of their transition to the Medi-Cal
32 program at least 60 days prior to the transition of individuals in
33 Phase 1, as described in subparagraph (A) of paragraph (1) of
34 subdivision ~~(d)~~ (e), and at least 90 days prior to transition of
35 individuals in Phases 2 ~~and 3~~, 3, *and 4*, as described in
36 subparagraphs (B) ~~and (C)~~, (C), *and (D)* of paragraph (1) of
37 subdivision ~~(d)~~ (e).

38 (3) Notices developed pursuant to this subdivision shall ensure
39 individuals are informed regarding the transition, including, but
40 not limited to, how individuals' systems of care may change, when

1 the changes will occur, and whom they can contact for assistance
2 when choosing a Medi-Cal managed care plan, if applicable,
3 including a toll-free telephone number, and with problems they
4 may encounter. The department shall consult with stakeholders
5 regarding notices developed pursuant to this subdivision. These
6 notices shall be developed using plain language, and written
7 translation of the notices shall be available for those who are
8 limited English proficient or non-English speaking in all Medi-Cal
9 threshold languages.

10 (4) The department shall designate department liaisons
11 responsible for the coordination of the Healthy Families Program
12 and may establish a children's-focused section for this purpose
13 and to facilitate the provision of health care services for children
14 enrolled in Medi-Cal.

15 (5) The department shall provide a process for ongoing
16 stakeholder consultation and make information publicly available,
17 including the achievement of benchmarks, enrollment data,
18 utilization data, and quality measures.

19 (g) (1) In order to aid the transition of Healthy Families Program
20 enrollees, MRMIB, on the effective date of the act that added this
21 section and continuing through the completion of the transition of
22 Healthy Families Program enrollees to the Medi-Cal program,
23 shall begin requesting and collecting from health plans contracting
24 with MRMIB pursuant to Part 6.2 (commencing with Section
25 12693) of Division 2 of the Insurance Code, information about
26 each health plan's provider network, including, but not limited to,
27 the primary care and all specialty care providers assigned to
28 individuals enrolled in the health plan. MRMIB shall obtain this
29 information in a manner that coincides with the transition activities
30 described in subdivision (d), and shall provide all of the collected
31 information to the department within 60 days of the department's
32 request for this information to ensure timely transitions of the
33 Healthy Family Programs enrollees.

34 (2) The department shall analyze the existing Healthy Families
35 Program delivery system network and the Medi-Cal fee-for-service
36 provider networks, including, but not limited to, Medi-Cal dental
37 providers, to determine overlaps of the provider networks in each
38 county for which there are no Medi-Cal managed care plans or
39 dental managed care plans. To the extent there is a lack of existing
40 Medi-Cal fee-for-service providers available to serve the Healthy

Families Program enrollees, the department shall work with the Healthy Families Program provider community to encourage participation of those providers in the Medi-Cal program, and develop a streamlined process to enroll them as Medi-Cal providers.

(3) (A) MRMIB, within 60 days of a request by the department, shall provide the department any data, information, or record concerning the Healthy Families Program as is necessary to implement the transition of enrollment required pursuant to this section.

(B) Notwithstanding any other provision of law, all of the following shall apply:

(i) The term “data, information, or record” shall include, but is not limited to, personal information as defined in Section 1798.3 of the Civil Code.

(ii) Any data, information, or record shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code) and any other law, to the same extent that it was exempt from disclosure or privileged prior to the provision of the data, information, or record to the department.

(iii) The provision of any such data, information, or record to the department shall not constitute a waiver of any evidentiary privilege or exemption from disclosure.

(iv) The department shall keep all data, information, or records provided by MRMIB confidential to the full extent permitted by law, including, but not limited to, the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code, and consistent with MRMIB’s contractual obligations to keep the data, information, or records confidential.

(h) This section shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(i) (1) The department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) of Section 14005.26 whose family income has been determined to be above 150 percent and up to and including 200

1 percent of the federal poverty level, after application of the income
2 disregard pursuant to subdivision (b) of Section 14005.26. The
3 department shall not impose premiums under this subdivision for
4 individuals described in subdivision (a) of Section 14005.26 whose
5 family income has been determined to be at or below 150 percent
6 of the federal poverty level, after application of the income
7 disregard pursuant to subdivision (b) of Section 14005.26. The
8 department shall obtain federal approval for the implementation
9 of this subdivision.

10 (2) All premiums imposed under this section shall equal the
11 family contributions described in paragraph (2) of subdivision (d)
12 of Section 12693.43 of the Insurance Code and shall be reduced
13 in conformity with subdivisions (e) and (f) of Section 12693.43
14 of the Insurance Code.

15 (j) The department shall not enroll targeted low-income children
16 described in this section in the Medi-Cal program until all
17 necessary federal approvals and waivers have been obtained, or
18 no sooner than January 1, 2013.

19 (k) (1) To the extent the new budget methodology pursuant to
20 paragraph (6) of subdivision (a) of Section 14154 is not fully
21 operational, for the purposes of implementing this section, for
22 individuals described in subdivision (a) whose family income has
23 been determined to be at or below 150 percent of the federal
24 poverty level, as determined pursuant to subdivision (b), the
25 department shall utilize the budgeting methodology for this
26 population as contained in the November 2011 Medi-Cal Local
27 Assistance Estimate for Medi-Cal county administration costs for
28 eligibility operations.

29 (2) For purposes of implementing this section, the department
30 shall include in the Medi-Cal Local Assistance Estimate an amount
31 for Medi-Cal eligibility operations associated with the transfer of
32 Healthy Families Program enrollees eligible pursuant to subdivision
33 (a) of Section 14005.26 and whose family income is determined
34 to be above 150 percent and up to and including 200 percent of
35 the federal poverty level, after application of the income disregard
36 pursuant to subdivision (b) of Section 14005.26. In developing an
37 estimate for this activity, the department shall consider the
38 projected number of final eligibility determinations each county
39 will process and projected county costs. Within 60 days of the
40 passage of the annual Budget Act, the department shall notify each

1 county of their allocation for this activity based upon the amount
2 allotted in the annual Budget Act for this purpose.

3 (l) When the new budget methodology pursuant to paragraph
4 (6) of subdivision (a) of Section 14154 is fully operational, the
5 new budget methodology shall be utilized to reimburse counties
6 for eligibility determinations made for individuals pursuant to this
7 section.

8 (m) Except as provided in subdivision (b), eligibility
9 determinations and annual redeterminations made pursuant to this
10 section shall be performed by county eligibility workers.

11 (n) In conducting the eligibility determinations for individuals
12 pursuant to this section and Section 14005.26, the following
13 reporting and performance standards shall apply to all counties:

14 (1) Counties shall report to the department, in a manner and for
15 a time period determined by the department, in consultation with
16 the County Welfare Directors Association, the number of
17 applications processed on a monthly basis, a breakout of the
18 applications based on income using the federal percentage of
19 poverty levels, the final disposition of each application, including
20 information on the approved Medi-Cal program, if applicable, and
21 the average number of days it took to make the final eligibility
22 determination for applications submitted directly to the county and
23 from the single point of entry (SPE).

24 (2) Notwithstanding any other law, the following performance
25 standards shall be applied to counties for eligibility determinations
26 for individuals eligible pursuant to this section:

27 (A) For children whose applications are received by the county
28 human services department from the SPE, the following standards
29 shall apply:

30 (i) Applications for children who are granted accelerated
31 enrollment by the SPE shall be processed according to the
32 timeframes specified in subdivision (d) of Section 14154.

33 (ii) Applications for children who are not granted accelerated
34 enrollment by the SPE due to the existence of an already active
35 Medi-Cal case shall be processed according to the timeframes
36 specified in subdivision (d) of Section 14154.

37 (iii) For applications for children who are not described in clause
38 (i) or (ii), 90 percent shall be processed within 10 working days
39 of being received, complete and without client errors.

1 (iv) If an application described in this section also contains
2 adults, and the adult applicants are required to submit additional
3 information beyond the information provided for the children, the
4 county shall process the eligibility for the child or children without
5 delay, consistent with this section while gathering the necessary
6 information to process eligibility for the adults.

7 (B) The department, in consultation with the County Welfare
8 Directors Association, shall develop reporting requirements for
9 the counties to provide regular data to the state regarding the
10 timeliness and outcomes of applications processed by the counties
11 that are received from the SPE.

12 (C) Performance thresholds and corrective action standards as
13 set forth in Section 14154 shall apply.

14 (D) For applications received directly into the county, these
15 applications shall be processed by the counties in accordance with
16 the performance standards established under subdivision (d) of
17 Section 14154.

18 (3) This subdivision shall be implemented ~~90 days after~~
19 ~~enactment of this section or January 1, 2013, whichever is later~~
20 *no sooner than January 1, 2013.*

21 (4) Twelve months after implementation of this section pursuant
22 to subdivision ~~(d)~~ (e), the department shall provide enrollment
23 information regarding individuals determined eligible pursuant to
24 subdivision (a) to the fiscal and appropriate policy committees of
25 the Legislature.

26 (o) (1) Notwithstanding Chapter 3.5 (commencing with Section
27 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
28 for purposes of this transition, the department, without taking any
29 further regulatory action, shall implement, interpret, or make
30 specific this section by means of all-county letters, plan letters,
31 plan or provider bulletins, or similar instructions until the time
32 regulations are adopted. It is the intent of the Legislature that the
33 department be allowed temporary authority as necessary to
34 implement program changes until completion of the regulatory
35 process.

36 (2) To the extent otherwise required by Chapter 3.5
37 (commencing with Section 11340) of Part 1 of Division 3 of Title
38 2 of the Government Code, the department shall adopt emergency
39 regulations implementing this section no later than July 1, 2014.
40 The department may thereafter readopt the emergency regulations

pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(p) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App Web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

~~(p)~~

(q) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or

1 parts thereof in order to receive federal financial participation, any
2 increase in the federal medical assistance percentage available on
3 or after October 1, 2008, or any additional federal funds that the
4 director, in consultation with the Department of Finance, has
5 determined would be advantageous to the state.

6 (2) The director shall retain the declaration described in
7 paragraph (1), shall provide a copy of the declaration to the
8 Secretary of the State, the Secretary of the Senate, the Chief Clerk
9 of the Assembly, and the Legislative Counsel, and shall post the
10 declaration on the department's Internet Web site.

11 (3) In the event that the director makes a determination under
12 paragraph (1) and this section ceases to be implemented, the
13 children shall be enrolled back into the Healthy Families Program.

14 *SEC. 15. Section 14105.18 of the Welfare and Institutions Code*
15 *is amended to read:*

16 14105.18. (a) Notwithstanding any other provision of law,
17 provider rates of payment for services rendered in all of the
18 following programs shall be identical to the rates of payment for
19 the same service performed by the same provider type pursuant to
20 the Medi-Cal program:-

21 (1) The California Children's Services Program established
22 pursuant to Article 5 (commencing with Section 123800) of
23 Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

24 (2) The Genetically Handicapped Person's Program established
25 pursuant to Article 1 (commencing with Section 125125) of
26 Chapter 2 of Part 5 of Division 106 of the Health and Safety Code.

27 (3) The Breast and Cervical Cancer Early Detection Program
28 established pursuant to Article 1.3 (commencing with Section
29 104150) of Chapter 2 of Part 1 of Division 103 of the Health and
30 Safety Code and the breast cancer programs specified in Section
31 30461.6 of the Revenue and Taxation Code.

32 (4) The State-Only Family Planning Program established
33 pursuant to Division 24 (commencing with Section 24000).

34 (5) The Family Planning, Access, Care, and Treatment (Family
35 PACT) Program established pursuant to subdivision (aa) of Section
36 14132.

37 (6) The Healthy Families Program established pursuant to Part
38 6.2 (commencing with Section 12693) of Division 2 of the
39 Insurance Code if the health care services are provided by a

1 Medi-Cal provider pursuant to subdivision (b) of Section 12693.26
2 of the Insurance Code.

3 (7) The Access for Infants and Mothers Program established
4 pursuant to Part 6.3 (commencing with Section 12695) of Division
5 2 of the Insurance Code if the health care services are provided by
6 a Medi-Cal provider.

7 (b) The director may identify in regulations other programs not
8 listed in subdivision (a) in which providers shall be paid rates of
9 payment that are identical to the rates of payments in the Medi-Cal
10 program pursuant to subdivision (a).

11 (c) Notwithstanding subdivision (a), services provided under
12 any of the programs described in subdivisions (a) and (b) may be
13 reimbursed at rates greater than the Medi-Cal rate that would
14 otherwise be applicable if those rates are adopted by the director
15 in regulations.

16 (d) *Payment increases made pursuant to Section 14105.196*
17 *shall not apply to provider rates of payment described in this*
18 *section for services provided to individuals not eligible for*
19 *Medi-Cal or Family Pact.*

20 ~~(d)~~

21 (e) This section shall become operative on January 1, 2011.

22 *SEC. 16. Section 14105.196 of the Welfare and Institutions*
23 *Code is amended to read:*

24 14105.196. (a) It is the intent of the Legislature to comply
25 with the provisions of the federal Health Care and Education
26 Reconciliation Act of 2010 (Public Law 111-152) and temporarily
27 increase reimbursement to certain primary care providers at the
28 same levels as Medicare rates for the 2013 and 2014 calendar years
29 for specified services.

30 (b) (1) Notwithstanding any other law, to the extent required
31 by federal law and regulations, beginning January 1, 2013, through
32 and including December 31, 2014, payments for primary care
33 services provided by a physician with a primary specialty
34 designation of family medicine, general internal medicine, or
35 pediatric medicine shall not be less than 100 percent of the payment
36 rate that applies to those services and physicians as established by
37 the Medicare Program, for both fee-for-service and managed care
38 plans.

39 (2) Notwithstanding any other law, to the extent required by
40 federal law and regulations, beginning January 1, 2013, through

1 and including December 31, 2014, the payments for primary care
2 services implemented pursuant to this section shall be exempt from
3 the payment reductions under Sections 14105.191 and 14105.192.

4 (3) *Payment increases made pursuant to this section shall not*
5 *apply to provider rates of payment described in Section 14105.18*
6 *for services provided to individuals not eligible for Medi-Cal or*
7 *the Family Planning, Access, Care, and Treatment (Family PACT)*
8 *Program.*

9 (c) For purposes of this section, “primary care services” and
10 “primary specialty” means the services and primary specialties
11 defined in Section 1202 of the federal Health Care and Education
12 Reconciliation Act of 2010 (Public Law 111-152; 42 U.S.C. Sec.
13 1396a(a)(13)(C)) and related federal regulations.

14 (d) Notwithstanding any other law, effective on or after January
15 1, 2013, the payment increase implemented pursuant to this section
16 shall apply to managed care health plans that contract with the
17 department pursuant to Chapter 8.75 (commencing with Section
18 14591) and to contracts with the Senior Care Action Network and
19 the AIDS Healthcare Foundation, and to the extent that the services
20 are provided through any of these contracts, payments shall be
21 increased by the actuarial equivalent amount of the payment
22 increases pursuant to contract amendments or change orders
23 effective on or after January 1, 2013.

24 (e) Notwithstanding Chapter 3.5 (commencing with Section
25 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
26 the department shall implement, clarify, make specific, and define
27 the provisions of this section by means of provider bulletins or
28 similar instructions, without taking regulatory action.

29 (f) Notwithstanding paragraph (1) of subdivision (b), if a final
30 judicial determination is made by any state or federal court that is
31 not appealed, in any action by any party, or a final determination
32 is made by the administrator of the federal Centers for Medicare
33 and Medicaid Services, that any payments pursuant to this section
34 are invalid, unlawful, or contrary to any provision of federal law
35 or regulations, or of state law, this section shall become inoperative.

36 (g) (1) The director shall implement the increased payments
37 for primary care services and primary specialties provided for in
38 this section only to the extent that the federal medical assistance
39 percentage is equal to 100 percent.

1 (2) In assessing whether federal financial participation is
2 available, the director shall determine whether the payments
3 comply with applicable federal Medicaid requirements, including
4 those set forth in Section 1396a(a)(30)(A) of Title 42 of the United
5 States Code.

6 (3) To the extent that the director determines that the payments
7 do not comply with applicable federal Medicaid requirements, the
8 director shall retain the discretion not to implement the changes
9 and may revise the payments as necessary to comply with the
10 federal Medicaid requirements.

11 (h) This section shall remain in effect only until January 1, 2015,
12 and as of that date is repealed, unless a later enacted statute, that
13 is enacted before January 1, 2015, deletes or extends that date.

14 *SEC. 17. Section 14132.24 of the Welfare and Institutions Code*
15 *is amended to read:*

16 14132.24. (a) The department shall develop and implement a
17 program to provide a community-living support benefit to eligible
18 Medi-Cal beneficiaries. The department shall submit any waiver
19 application, modification of any existing waiver, or amendment
20 to the Medicaid state plan, that is necessary to provide this benefit,
21 and shall implement the benefit only to the extent that federal
22 financial participation is available.

23 (b) The community-living support benefit shall include both of
24 the following:

25 (1) (A) Reimbursement for an array of health-related and
26 psychosocial services provided or coordinated at community-based
27 housing sites that enable beneficiaries to remain in the least
28 restrictive and most homelike environment while receiving the
29 health-related services, including personal care and psychosocial
30 services, necessary to protect their health and well-being. These
31 community-based housing units may include, but are not limited
32 to, the living area or unit within a facility that is specifically
33 designed to provide ongoing assisted living services, licensed
34 residential care facilities for the elderly, publicly funded senior
35 and disabled housing projects, or supportive housing sites that
36 serve chronically homeless individuals with chronic or disabling
37 health conditions.

38 (B) For purposes of this section, “assisted living services”
39 includes, but is not limited to, assistance with personal activities
40 of daily living, including dressing, feeding, toileting, bathing,

grooming, mobility, and associated tasks, to help provide for and maintain physical and psychological comfort.

(2) Access to community-living support services provided or coordinated at the community-based housing site, including, but not limited to, the personal care and health services specified in paragraph (8) of subdivision (a) of Section 1788 of the Health and Safety Code, and the health related support services specified in Section 53290 of the Health and Safety Code.

(c) Services available through the community-living support benefit shall not duplicate services available through the Medi-Cal state plan, other Medi-Cal waivers, or other programs financed by the state.

(d) An individual shall be eligible for the community-living support benefit if he or she is eligible for the Medi-Cal program, is a resident of San Francisco who would otherwise be homeless, living in shelters, or institutionalized, and meets one or both of the following criteria:

(1) ~~The State Department of Mental Health~~ *department* determines that he or she would benefit from supportive housing, as defined in subdivision (c) of Section 53260 of the Health and Safety Code.

(2) The department determines that he or she is eligible for placement in a skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, or an intermediate care facility, as defined in subdivision (d) of that section.

(e) The department may modify the eligibility criteria specified in subdivision (d), if needed, to qualify the community-living support benefit for federal financial participation.

(f) The department shall seek to maximize resources for community-based housing by coordinating the community-living support benefit with existing efforts to coordinate care, improve health outcomes, and reduce long-term care costs for the targeted population.

(g) This section shall be implemented only upon adoption of a resolution by the Board of Supervisors of the City and County of San Francisco providing county funds for use by the state to match federal Medicaid funds to receive federal funds for services provided under the waiver specified in this section, and for any

1 costs associated with implementing and monitoring the waiver, to
2 limit additional state costs.

3 *SEC. 18. Section 14132.275 of the Welfare and Institutions*
4 *Code, as amended by Section 1 of Chapter 33 of the Statutes of*
5 *2012, is amended to read:*

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

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

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

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

39 (2) “Capitated payment model” means an agreement entered
40 into between CMS, the state, and a managed care health plan, in

1 which the managed care health plan receives a capitation payment
2 for the comprehensive, coordinated provision of Medi-Cal services
3 and benefits under Medicare Part C (42 U.S.C. Sec. 1395w-21 et
4 seq.) and Medicare Part D (42 U.S.C. Sec. 1395w-101 et seq.),
5 and CMS shares the savings with the state from improved provision
6 of Medi-Cal and Medicare services that reduces the cost of those
7 services. Medi-Cal services include long-term services and supports
8 as defined in Section 14186.1, behavioral health services, and any
9 additional services offered by the demonstration site.

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

13 (4) “Dual eligible beneficiary” means an individual 21 years of
14 age or older who is enrolled for benefits under Medicare Part A
15 (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C.
16 Sec. 1395j et seq.) and is eligible for medical assistance under the
17 Medi-Cal State Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (B) Be in good financial standing and meet licensure
8 requirements under the Knox-Keene Health Care Service Plan Act
9 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division
10 2 of the Health and Safety Code), except for county organized
11 health system plans that are exempt from licensure pursuant to
12 Section 14087.95.

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

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

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

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

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

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

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

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

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

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

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

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

12 (9) To the extent permissible under federal requirements,
13 implementation of the provisions of Sections 14182.16 and
14 14182.17 that are applicable to beneficiaries simultaneously eligible
15 for full-scope benefits under Medi-Cal and the Medicare Program.

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

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

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

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

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

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

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

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

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

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

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

18 (k) The director may enter into exclusive or nonexclusive
19 contracts on a bid or negotiated basis and may amend existing
20 managed care contracts to provide or arrange for services provided
21 under this section. Contracts entered into or amended pursuant to
22 this section shall be exempt from the provisions of Chapter 2
23 (commencing with Section 10290) of Part 2 of Division 2 of the
24 Public Contract Code and Chapter 6 (commencing with Section
25 14825) of Part 5.5 of Division 3 of Title 2 of the Government
26 Code.

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

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

7 (C) (i) Persons meeting requirements for the Program of
8 All-Inclusive Care for the Elderly (PACE) pursuant to Chapter
9 8.75 (commencing with Section 14591) or 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) of
15 Chapter 7 to provide services to beneficiaries who are HIV positive
16 or who have been diagnosed with AIDS may select either of these
17 managed care health plans for their Medicare and Medi-Cal benefits
18 if one is available in that county.

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

33 (2) To the extent that federal approval is obtained, the
34 department may require that any beneficiary, upon enrollment in
35 a demonstration site, remain enrolled in the Medicare portion of
36 the demonstration project on a mandatory basis for six months
37 from the date of initial enrollment. After the sixth month, a dual
38 eligible beneficiary may elect to enroll in a different demonstration
39 site, a different Medicare Advantage plan, fee-for-service Medicare,
40 PACE, or a managed care organization licensed under the

1 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
2 (commencing with Section 1340) of Division 2 of the Health and
3 Safety Code) that has previously contracted with the department
4 as a primary care case management plan pursuant to Article 2.9
5 (commencing with Section 14088) to provide services to
6 beneficiaries who are HIV positive or who have been diagnosed
7 with AIDS, for his or her Medicare benefits.

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

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

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

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

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

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

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

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

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

1 for persons enrolled in ~~Community-Based Adult Services or~~
2 Multipurpose Senior Services Program services.

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

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

8 (vi) The beneficiary resides in one of the Veterans' Homes of
9 California, as described in Chapter 1 (commencing with Section
10 1010) of Division 5 of the Military and Veterans Code.

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

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

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

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

28 ~~(III) To county administrators of the local low-income health~~
29 ~~programs (LHHPs).~~

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

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

38 (4) For the 2013 calendar year, the department shall offer federal
39 Medicare Improvements for Patients and Providers Act of 2008
40 (Public Law 110-275) compliant contracts to existing Medicare

1 Advantage Special Needs Plans (D-SNP plans) to continue to
2 provide Medicare benefits to their enrollees in their service areas
3 as approved on January 1, 2012. In the 2013 calendar year,
4 beneficiaries in Medicare Advantage and D-SNP plans shall be
5 exempt from the enrollment provisions of subparagraph (A) of
6 paragraph (1), but may voluntarily choose to enroll in the
7 demonstration project. Enrollment into the demonstration project's
8 managed care health plans shall be reassessed in 2014 depending
9 on federal reauthorization of the D-SNP model and the
10 department's assessment of the demonstration plans.

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

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

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

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

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

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

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

4 (3) Reimbursement policies shall not prevent demonstration
5 sites and providers from entering into payment arrangements that
6 allow for the alignment of financial incentives and provide
7 opportunities for shared risk and shared savings in order to promote
8 appropriate utilization shifts, which encourage the use of home-
9 and community-based services and quality of care for dual eligible
10 beneficiaries enrolled in the demonstration sites.

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

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

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

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

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

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

38 (p) The department shall enter into an interagency agreement
39 with the Department of Managed Health Care to perform some or
40 all of the department's oversight and readiness review activities

1 specified in this section. These activities may include providing
2 consumer assistance to beneficiaries affected by this section and
3 conducting financial audits, medical surveys, and a review of the
4 adequacy of provider networks of the managed care health plans
5 participating in this section. The interagency agreement shall be
6 updated, as necessary, on an annual basis in order to maintain
7 functional clarity regarding the roles and responsibilities of the
8 Department of Managed Health Care and the department. The
9 department shall not delegate its authority under this section as
10 the single state Medicaid agency to the Department of Managed
11 Health Care.

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

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

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

38 (C) The department shall publish the results of these measures,
39 including via posting on the department’s Internet Web site, on a
40 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.

SEC. 19. Section 14132.276 of the Welfare and Institutions Code, as added by Section 2 of Chapter 33 of the Statutes of 2012, is amended to read:

14132.276. For nursing facility services provided under the demonstration project as established in Section 14132.275, to the extent ~~these services are authorized under the demonstration project~~ *provisions are authorized under the memorandum of understanding specified in subdivision (j) of Section 14132.275*, the following shall apply:

(a) The demonstration site shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services.

(b) The demonstration site shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

(c) For the purposes of determining the appropriate rate for the type of care identified in subdivision (b), the demonstration site shall pay no less than the recognized rates under Medicare and Medi-Cal for these service types.

(d) With respect to services under this section, the demonstration site shall not offer, and the nursing facility shall not accept, any discounts, rebates, or refunds as compensation or inducements for the referral of patients or residents.

(e) It is the intent of the Legislature that savings under the demonstration projects be achieved through shifts in utilization, and not through reduced reimbursement rates to providers.

(f) In order to encourage quality improvement and promote appropriate utilization incentives, including reduced rehospitization and shorter lengths of stay, for nursing facilities providing the services under this section, the demonstration sites may do any of the following:

(1) Utilize incentive or bonus payment programs that are in addition to the rates identified in subdivisions (b) and (c).

(2) Opt to direct beneficiaries to facilities that demonstrate better performance on quality or appropriate utilization factors.

SEC. 20. Section 14139.22 of the Welfare and Institutions Code is amended to read:

14139.22. (a) The department shall convene a working group that shall include the Director of Health Care Services, the Director of Social Services, and the Director of the California Department of Aging, or the program staff from each of those departments who have direct responsibility for the programs listed in subdivision (b) of Section 14139.32, and may include ~~the Director of Mental Health~~ and the Director of Rehabilitation, or program staff from those departments with direct responsibilities for programs that may be included as a service in any pilot project site, and representatives from each pilot project site upon its selection.

(b) The department shall consult with the working group during the designing of the pilot program, in the selection of the pilot project sites, and in the monitoring of the program under this article, and shall utilize the working group as a resource for ~~problem-solving~~ *problem solving* and a means of maintaining interdepartmental and intersite communication.

(c) The working group shall strive to ensure that the pilot program under this article makes maximum use of home-based and community-based services, and throughout the continuum of care for each beneficiary, encourages the use of the least restrictive environment in which the beneficiary can receive appropriate care.

SEC. 21. Section 14166.12 of the Welfare and Institutions Code, as amended by Section 90 of Chapter 23 of the Statutes of 2012, is amended to read:

14166.12. (a) The California Medical Assistance Commission shall negotiate payment amounts, in accordance with the selective

provider contracting program established pursuant to Article 2.6 (commencing with Section 14081), from the Private Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to private hospitals that satisfy the criteria of subdivision (s). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) The Private Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, “fund” means the Private Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One hundred eighteen million four hundred thousand dollars (\$118,400,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program, except as follows:

(A) For the 2008–09 fiscal year, this amount shall be reduced by thirteen million six hundred thousand dollars (\$13,600,000) and by an amount equal to one-half of the difference between eighteen million three hundred thousand dollars (\$18,300,000) and the amount of any reduction in the additional payments for distressed hospitals calculated pursuant to subparagraph (B) of paragraph (3) of subdivision (b) of Section 14166.20.

(B) For the 2012–13 fiscal year, this amount shall be reduced by seventeen million five hundred thousand dollars (\$17,500,000).

(C) For the 2013–14 fiscal year, this amount shall be reduced by eight million seven hundred fifty thousand dollars (\$8,750,000).

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund pursuant to paragraph (2) of subdivision (a) of Section 14166.14.

(4) Any moneys that any county, other political subdivision of the state, or other governmental entity in the state may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

1 (5) All private moneys donated by private individuals or entities
2 to the department for deposit in the fund as permitted under
3 applicable federal Medicaid laws.

4 (6) Any interest that accrues on amounts in the fund.

5 (e) Any public agency transferring moneys to the fund may, for
6 that purpose, utilize any revenues, grants, or allocations received
7 from the state for health care programs or purposes, unless
8 otherwise prohibited by law. A public agency may also utilize its
9 general funds or any other public moneys or revenues for purposes
10 of transfers to the fund, unless otherwise prohibited by law.

11 (f) The department may accept or not accept moneys offered to
12 the department for deposit in the fund. If the department accepts
13 moneys pursuant to this section, the department shall obtain federal
14 financial participation to the full extent permitted by law. With
15 respect to funds transferred or donated from private individuals or
16 entities, the department shall accept only those funds that are
17 certified by the transferring or donating entity that qualify for
18 federal financial participation under the terms of the Medicaid
19 Voluntary Contribution and Provider-Specific Tax Amendments
20 of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the
21 Code of Federal Regulations, as applicable. The department may
22 return any funds transferred or donated in error.

23 (g) Moneys in the fund shall be used as the source for the
24 nonfederal share of payments to hospitals under this section.

25 (h) Any funds remaining in the fund at the end of a fiscal year
26 shall be carried forward for use in the following fiscal year.

27 (i) Moneys shall be allocated from the fund by the department
28 and shall be applied to obtain federal financial participation in
29 accordance with customary Medi-Cal accounting procedures for
30 purposes of payments under this section. Distributions from the
31 fund shall be supplemental to any other Medi-Cal reimbursement
32 received by the hospitals, including amounts that hospitals receive
33 under the selective provider contracting program (Article 2.6
34 (commencing with Section 14081)), and shall not affect provider
35 rates paid under the selective provider contracting program.

36 (j) Each private hospital that was a private hospital during the
37 2002–03 fiscal year, received payments for the 2002–03 fiscal
38 year from any of the prior supplemental funds, and, during the
39 project year, satisfies the criteria in subdivision (s) to be eligible
40 to negotiate for distributions under any of those sections, shall

1 receive no less from the Private Hospital Supplemental Fund for
2 the project year than 100 percent of the amount the hospital
3 received from the prior supplemental funds for the 2002–03 fiscal
4 year. Each private hospital described in this subdivision shall be
5 eligible for additional payments from the fund pursuant to
6 subdivision (k).

7 (k) All amounts that are in the fund for a project year in excess
8 of the amount necessary to make the payments under subdivision
9 (j) shall be available for negotiation by the California Medical
10 Assistance Commission, along with corresponding federal financial
11 participation, for supplemental payments to private hospitals, which
12 for the project year satisfy the criteria under subdivision (s) to be
13 eligible to negotiate for distributions under any of those sections,
14 and paid for services rendered during the project year pursuant to
15 the selective provider contracting program established under Article
16 2.6 (commencing with Section 14081).

17 (l) The amount of any stabilization funding transferred to the
18 fund, or the amount of intergovernmental transfers deposited to
19 the fund pursuant to subdivision (o), together with the associated
20 federal reimbursement, with respect to a particular project year,
21 may, in the discretion of the California Medical Assistance
22 Commission, until its dissolution on June 30, 2012, be paid for
23 services furnished in the same project year regardless of when the
24 stabilization funds or intergovernmental transfer funds, and the
25 associated federal reimbursement, become available, provided the
26 payment is consistent with other applicable federal or state law
27 requirements and does not result in a hospital exceeding any
28 applicable reimbursement limitations. On and after July 1, 2012,
29 the Director of Health Care Services shall exercise the discretion
30 granted to the California Medical Assistance Commission by this
31 subdivision.

32 (m) The department shall pay amounts due to a private hospital
33 from the fund for a project year, with the exception of stabilization
34 funding, in up to four installment payments, unless otherwise
35 provided in the hospital’s contract negotiated with the California
36 Medical Assistance Commission, except that hospitals that are not
37 described in subdivision (j) shall not receive the first installment
38 payment. The first payment shall be made as soon as practicable
39 after the issuance of the tentative disproportionate share hospital
40 list for the project year, and in no event later than January 1 of the

1 project year. The second and subsequent payments shall be made
2 after the issuance of the final disproportionate hospital list for the
3 project year, and shall be made only to hospitals that are on the
4 final disproportionate share hospital list for the project year. The
5 second payment shall be made by February 1 of the project year
6 or as soon as practicable after the issuance of the final
7 disproportionate share hospital list for the project year. The third
8 payment, if scheduled, shall be made by April 1 of the project year.
9 The fourth payment, if scheduled, shall be made by June 30 of the
10 project year. This subdivision does not apply to hospitals that are
11 scheduled to receive payments from the fund because they meet
12 the criteria under paragraph (2) of subdivision (s) and do not meet
13 the criteria under paragraph (1), (3), or (4) of subdivision (s), which
14 shall be paid in accordance with the applicable contract or contract
15 amendment negotiated by the California Medical Assistance
16 Commission.

17 (n) The department shall pay stabilization funding transferred
18 to the fund in amounts negotiated by the California Medical
19 Assistance Commission and shall pay the scheduled payments in
20 accordance with the applicable contract or contract amendment.

21 (o) Payments to private hospitals that are eligible to receive
22 payments pursuant to subdivision (s) may be made using funds
23 transferred from governmental entities to the state, at the option
24 of the governmental entity. Any payments funded by
25 intergovernmental transfers shall remain with the private hospital
26 and shall not be transferred back to any unit of government. An
27 amount equal to 25 percent of the amount of any intergovernmental
28 transfer made in the project year that results in a supplemental
29 payment made for the same project year to a project year private
30 DSH hospital designated by the governmental entity that made the
31 intergovernmental transfer shall be deposited in the fund for
32 distribution as determined by the California Medical Assistance
33 Commission. An amount equal to 75 percent shall be deposited in
34 the fund and distributed to the private hospitals designated by the
35 governmental entity.

36 (p) A private hospital that receives payment pursuant to this
37 section for a particular project year shall not submit a notice for
38 the termination of its participation in the selective provider
39 contracting program established pursuant to Article 2.6

(commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(q) (1) For the 2007–08, 2008–09, and 2009–10 project years, the County of Los Angeles shall make intergovernmental transfers to the state to fund the nonfederal share of increased Medi-Cal payments to those private hospitals that serve the South Los Angeles population formerly served by Los Angeles County Martin Luther King, Jr.-Harbor Hospital. The intergovernmental transfers required under this subdivision shall be funded by county tax revenues and shall total five million dollars (\$5,000,000) per project year, except that, in the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount of intergovernmental transfers required under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in Los Angeles County Martin Luther King, Jr.-Harbor Hospital's baseline, as determined under subdivision (c) of Section 14166.5 for that project year.

(2) Notwithstanding subdivision (o), an amount equal to 100 percent of the county's intergovernmental transfers under this subdivision shall be deposited in the fund and, within 30 days after receipt of the intergovernmental transfer, shall be distributed, together with related federal financial participation, to the private hospitals designated by the county in the amounts designated by the county. The director shall disregard amounts received pursuant to this subdivision in calculating the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining the amount of disproportionate share hospital replacement payments due a private hospital under Section 14166.11.

(r) (1) The reductions in supplemental payments under this section that result from the reductions in the amounts transferred from the General Fund to the Private Hospital Supplemental Fund for the 2012–13 and 2013–14 fiscal years under subparagraphs (B) and (C) of paragraph (1) of subdivision (d) shall be allocated equally in the aggregate between children's hospitals eligible for

1 supplemental payments under this section and other hospitals
2 eligible for supplemental payments under this section. When
3 negotiating payment amounts to a hospital under this section for
4 the 2012–13 and 2013–14 fiscal years, the California Medical
5 Assistance Commission, or its successor agency, shall identify
6 both a payment amount that would have been made absent the
7 funding reductions in subparagraphs (B) and (C) of paragraph (1)
8 of subdivision (d) and the payment amount that will be made taking
9 into account the funding reductions under subparagraphs (B) and
10 (C) of paragraph (1) of subdivision (d). For purposes of this
11 subdivision, “children’s hospital” shall have the meaning set forth
12 in paragraph (13) of subdivision (a) of Section 14105.98.

13 (2) This subdivision shall not preclude the department from
14 including some or all of the reductions under this section within
15 the payments made under a new diagnosis-related group payment
16 methodology for the 2012–13 fiscal year or the 2013–14 fiscal
17 year. In the event the department includes some or all of the
18 amounts, including reductions, within the payments made under
19 a new diagnosis-related group payment methodology for the
20 2012–13 fiscal year or the 2013–14 fiscal year, the department, in
21 implementing the reductions in paragraph (1) of subdivision (d),
22 shall, to the extent feasible, utilize the allocation specified in
23 paragraph (1).

24 (s) In order for a hospital to receive distributions pursuant to
25 ~~this section~~ *Article 2.6 (commencing with Section 14081)*, the
26 hospital shall satisfy the eligibility criteria in paragraph (1), (2),
27 (3), or (4) of this subdivision.

28 (1) The hospital meets all of the following criteria:

29 (A) The hospital is contracting under ~~this article~~ *Article 2.6*
30 *(commencing with Section 14081)*.

31 (B) The hospital meets the criteria contained in the Medicaid
32 State Plan for disproportionate share hospital status.

33 (C) The hospital is one of the following:

34 (i) A licensed provider of basic emergency services as described
35 in Section 70411 of Title 22 of the California Code of Regulations.

36 (ii) A licensed provider of comprehensive emergency medical
37 services as defined in Section 70451 of Title 22 of the California
38 Code of Regulations.

39 (iii) A children’s hospital, as defined in Section 14087.21, that
40 satisfies clause (i) or (ii), or that jointly provides basic or

1 comprehensive emergency services in conjunction with another
2 licensed hospital.

3 (iv) A hospital owned and operated by a public agency that
4 operates two or more hospitals that qualify under subparagraph
5 (A) or (B) with respect to the particular state fiscal year.

6 (v) A hospital designated by the National Cancer Institute as a
7 comprehensive or clinical cancer research center that primarily
8 treats acutely ill cancer patients and that is exempt from the federal
9 Medicare prospective payment system pursuant to Section
10 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C.
11 Sec. 1395ww(d)(1)(B)(v)).

12 (D) The hospital is able to demonstrate a purpose for additional
13 funding under the selective provider contracting program including
14 proposals relating to emergency services and other health care
15 services, including infrequent yet high-cost services, such as
16 anti-AB human antitoxin treatment for infant botulism (human
17 botulinum immune globulin (HBIG), commonly referred to as
18 “Baby-BIG”), that are made available, or will be made available,
19 to Medi-Cal beneficiaries.

20 (2) The hospital is contracting under ~~this article~~ *Article 2.6*
21 *(commencing with Section 14081)* and meets the definition of a
22 university teaching hospital or major, nonuniversity, teaching
23 hospital as set forth on page 51 and as listed on page 57 of the
24 department’s report dated May 1991, entitled “Hospital Peer
25 Grouping.” Payments from the fund shall be used solely for the
26 purposes identified in the contract between the hospital and the
27 state.

28 (3) The hospital is contracting under ~~this article~~ *Article 2.6*
29 *(commencing with Section 14081)*, and meets the definition of any
30 of the following:

31 (A) A large teaching emphasis hospital, as set forth on page 51
32 and listed on page 57 of the department’s report dated May 1991,
33 entitled “Hospital Peer Grouping,” and also meets the definition
34 of eligible hospital as defined in paragraph (3) of subdivision (a)
35 of Section 14105.98.

36 (B) A children’s hospital pursuant to Section 10727, and also
37 meets the definition of eligible hospital as defined in paragraph
38 (3) of subdivision (a) of Section 14105.98.

39 (C) Notwithstanding the requirement in subparagraph (A) that
40 a hospital must be listed on page 57 of the department’s report

1 dated May 1991, entitled “Hospital Peer Grouping,” any hospital
2 whose license pursuant to Chapter 2 (commencing with Section
3 1250) of Division 2 of the Health and Safety Code was
4 consolidated during the 1999 calendar year with a large teaching
5 emphasis hospital that is listed on page 57 of the above-described
6 report shall be eligible. All other requirements of paragraph (3)
7 shall continue to apply.

8 (4) The hospital meets all of the following criteria:

9 (A) The hospital is contracting under ~~this article~~ *Article 2.6*
10 *(commencing with Section 14081)*.

11 (B) The hospital satisfies the Medicaid State Plan criteria for
12 disproportionate share hospital status.

13 (C) The hospital is a small and rural hospital as defined in
14 Section 124840 of the Health and Safety Code.

15 (D) The hospital is a licensed provider of standby emergency
16 services as described in Section 70649 of Title 22 of the California
17 Code of Regulations.

18 (E) The hospital is able to demonstrate a purpose for additional
19 funding under the selective provider contracting program with
20 proposals relating to health care services that are made available,
21 or will be made available, to Medi-Cal beneficiaries.

22 (F) The hospital is determined by the California Medical
23 Assistance Commission to be a hospital that provides an important
24 community service that otherwise would not be provided in the
25 community.

26 *SEC. 22. Section 14166.17 of the Welfare and Institutions*
27 *Code, as amended by Section 97 of Chapter 23 of the Statutes of*
28 *2012, is amended to read:*

29 14166.17. (a) The California Medical Assistance Commission
30 shall negotiate payment amounts in accordance with the selective
31 provider contracting program established pursuant to Article 2.6
32 (commencing with Section 14081) from the Nondesignated Public
33 Hospital Supplemental Fund established pursuant to subdivision
34 (b) for distribution to nondesignated public hospitals that satisfy
35 the criteria of subdivision (c). Pursuant to Section 14165, on and
36 after July 1, 2012, the Director of Health Care Services shall
37 exercise the discretion granted to the California Medical Assistance
38 Commission.

39 (b) The Nondesignated Public Hospital Supplemental Fund is
40 hereby established in the State Treasury. For purposes of this

1 section, “fund” means the Nondesignated Public Hospital
2 Supplemental Fund.

3 (c) Notwithstanding Section 13340 of the Government Code,
4 the fund shall be continuously appropriated to the department for
5 the purposes specified in this section.

6 (d) Except as otherwise limited by this section, the fund shall
7 consist of all of the following:

8 (1) One million nine hundred thousand dollars (\$1,900,000),
9 which shall be transferred annually from General Fund amounts
10 appropriated in the annual Budget Act for the fund.

11 (2) Any additional moneys appropriated to the fund.

12 (3) All stabilization funding transferred to the fund.

13 (4) All private moneys donated by private individuals or entities
14 to the department for deposit in the fund as permitted under
15 applicable federal Medicaid laws.

16 (5) Any interest that accrues on amounts in the fund.

17 (e) The department may accept or not accept moneys offered
18 to the department for deposit in the fund. If the department accepts
19 moneys pursuant to this section, the department shall obtain federal
20 financial participation to the full extent permitted by law. With
21 respect to funds transferred or donated from private individuals or
22 entities, the department shall accept only those funds that are
23 certified by the transferring or donating entity as qualifying for
24 federal financial participation under the terms of the Medicaid
25 Voluntary Contribution and Provider-Specific Tax Amendments
26 of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the
27 Code of Federal Regulations, as applicable. The department may
28 return any funds transferred or donated in error.

29 (f) Moneys in the funds shall be used as the source for the
30 nonfederal share of payments to hospitals under this section.

31 (g) Any funds remaining in the fund at the end of a fiscal year
32 shall be carried forward for use in the following fiscal year.

33 (h) Moneys shall be allocated from the fund by the department
34 and shall be applied to obtain federal financial participation in
35 accordance with customary Medi-Cal accounting procedures for
36 purposes of payments under this section. Distributions from the
37 fund shall be supplemental to any other Medi-Cal reimbursement
38 received by the hospitals, including amounts that hospitals receive
39 under the selective provider contracts negotiated under Article 2.6

(commencing with Section 14081), and shall not affect provider rates paid under the selective provider contracting program.

(i) Each nondesignated public hospital that was a nondesignated public hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year satisfies the criteria in subdivision (o) to be eligible to negotiate for distributions under any of those sections shall receive no less from the Nondesignated Public Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year, minus the total amount of intergovernmental transfers made by or on behalf of the hospital pursuant to subdivision (o) for the same fiscal year. Each hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (j).

(j) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (i) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to nondesignated public hospitals that for the project year satisfy the criteria under subdivision (o) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program under Article 2.6 (commencing with Section 14081).

(k) The amount of any stabilization funding transferred to the fund with respect to a project year may in the discretion of the California Medical Assistance Commission, until its dissolution on June 30, 2012, to be paid for services furnished in the same project year regardless of when the stabilization funds become available, provided the payment is consistent with other applicable federal or state legal requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(l) The department shall pay amounts due to a nondesignated hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the

California Medical Assistance Commission, except that hospitals that are not described in subdivision (i) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (o) but do not meet the criteria under paragraph (1), (3), or (4) of subdivision (o).

(m) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and paid in accordance with the applicable contract or contract amendment.

(n) A nondesignated public hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(o) In order for a hospital to receive distributions pursuant to ~~this section~~ Article 2.6 (commencing with Section 14081), the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under ~~this article~~ Article 2.6 (commencing with Section 14081).

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

1 (i) A licensed provider of basic emergency services as described
2 in Section 70411 of Title 22 of the California Code of Regulations.

3 (ii) A licensed provider of comprehensive emergency medical
4 services as defined in Section 70451 of Title 22 of the California
5 Code of Regulations.

6 (iii) A children's hospital, as defined in Section 14087.21, that
7 satisfies clause (i) or (ii), or that jointly provides basic or
8 comprehensive emergency services in conjunction with another
9 licensed hospital.

10 (iv) A hospital owned and operated by a public agency that
11 operates two or more hospitals that qualify under subparagraph
12 (A) or (B) with respect to the particular state fiscal year.

13 (v) A hospital designated by the National Cancer Institute as a
14 comprehensive or clinical cancer research center that primarily
15 treats acutely ill cancer patients and that is exempt from the federal
16 Medicare prospective payment system pursuant to Section
17 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C.
18 Sec. 1395ww(d)(1)(B)(v)).

19 (D) (1) The hospital is able to demonstrate a purpose for
20 additional funding under the selective provider contracting program
21 including proposals relating to emergency services and other health
22 care services, including infrequent yet high-cost services, such as
23 anti-AB human antitoxin treatment for infant botulism (human
24 botulinum immune globulin (HBIG), commonly referred to as
25 "Baby-BIG"), that are made available, or will be made available,
26 to Medi-Cal beneficiaries.

27 (2) The hospital is contracting under ~~this article~~ *Article 2.6*
28 *(commencing with Section 14081)* and meets the definition of a
29 university teaching hospital or major, nonuniversity, teaching
30 hospital as set forth on page 51 and as listed on page 57 of the
31 department's report dated May 1991, entitled "Hospital Peer
32 Grouping." Payments from the fund shall be used solely for the
33 purposes identified in the contract between the hospital and the
34 state.

35 (3) The hospital is contracting under ~~this article~~ *Article 2.6*
36 *(commencing with Section 14081)* and meets the definition of any
37 of the following:

38 (A) A large teaching emphasis hospital, as set forth on page 51
39 and listed on page 57 of the department's report dated May 1991,
40 entitled "Hospital Peer Grouping," and also meets the definition

1 of eligible hospital as defined in paragraph (3) of subdivision (a)
2 of Section 14105.98.

3 (B) A children's hospital pursuant to Section 10727, and also
4 meets the definition of eligible hospital as defined in paragraph
5 (3) of subdivision (a) of Section 14105.98.

6 (C) Notwithstanding the requirement in subparagraph (A) of
7 paragraph (3) that a hospital must be listed on page 57 of the
8 department's report dated May 1991, entitled "Hospital Peer
9 Grouping," any hospital whose license pursuant to Chapter 2
10 (commencing with Section 1250) of Division 2 of the Health and
11 Safety Code was consolidated during the 1999 calendar year with
12 a large teaching emphasis hospital that is listed on page 57 of the
13 above-described report shall be eligible. All other requirements of
14 paragraph (3) shall continue to apply.

15 (4) The hospital meets all of the following criteria:

16 (A) The hospital is contracting under ~~this article~~ *Article 2.6*
17 *(commencing with Section 14081)*.

18 (B) The hospital satisfies the Medicaid State Plan criteria for
19 disproportionate share hospital status.

20 (C) The hospital is a small and rural hospital as defined in
21 Section 124840 of the Health and Safety Code.

22 (D) The hospital is a licensed provider of standby emergency
23 services as described in Section 70649 of Title 22 of the California
24 Code of Regulations.

25 (E) The hospital is able to demonstrate a purpose for additional
26 funding under the selective provider contracting program with
27 proposals relating to health care services that are made available,
28 or will be made available, to Medi-Cal beneficiaries.

29 (F) The hospital is determined by the California Medical
30 Assistance Commission to be a hospital that provides an important
31 community service that otherwise would not be provided in the
32 community.

33 *SEC. 23. Section 14182.16 of the Welfare and Institutions*
34 *Code, as added by Section 4 of Chapter 33 of the Statutes of 2012,*
35 *is amended to read:*

36 14182.16. (a) The department shall require Medi-Cal
37 beneficiaries who have dual eligibility in Medi-Cal and the
38 Medicare Program to be assigned as mandatory enrollees into new
39 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.

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

(1) “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) “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) “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) “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) “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) “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

1 care health plan if the dual eligible beneficiary meets any of the
2 following:

3 (A) Except in counties with county organized health systems
4 operating pursuant to Article 2.8 (commencing with Section
5 14087.5), the beneficiary has other health coverage.

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

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

10 ~~(D) The beneficiary is enrolled in a home- and community-based~~
11 ~~waiver that is a Medi-Cal benefit under Section 1915(c) of the~~
12 ~~federal Social Security Act (42 U.S.C. Sec. 1396n), except for~~
13 ~~persons enrolled in Community-Based Adult Services,~~
14 ~~Multipurpose Senior Services Program services, or a Section~~
15 ~~1915(c) waiver for persons with developmental disabilities.~~

16 ~~(E)~~

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

20 ~~(F)~~

21 (E) The beneficiary resides in one of the Veterans Homes of
22 California, as described in Chapter 1 (commencing with Section
23 1010) of Division 5 of the Military and Veterans Code.

24 ~~(G)~~

25 (F) The beneficiary is enrolled in any entity with a contract with
26 the department pursuant to Chapter 8.75 (commencing with Section
27 14591).

28 ~~(H)~~

29 (G) The beneficiary is enrolled in a managed care organization
30 licensed under the Knox-Keene Health Care Service Plan Act of
31 1975 (Chapter 2.2 (commencing with Section 1340) of Division
32 2 of the Health and Safety Code) that has previously contracted
33 with the department as a primary care case management plan
34 pursuant to Article 2.9 (commencing with Section 14088) of
35 Chapter 7.

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

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

4 (e) At the director's sole discretion, in consultation with
5 stakeholders, the department may determine and implement a
6 phased-in enrollment approach that may include Medi-Cal
7 beneficiary enrollment into managed care health plans immediately
8 upon implementation of this section in a specific county, over a
9 12-month period, or other phased approach. The phased-in
10 enrollment shall commence no sooner than March 1, 2013, and
11 not until all necessary federal approvals have been obtained.

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

16 (g) Except in a county where Medi-Cal services are provided
17 by a county organized health system, and notwithstanding any
18 other law, in any county in which fewer than two existing managed
19 health care plans contract with the department to provide Medi-Cal
20 services under this chapter that are available to dual eligible
21 beneficiaries, including long-term services and supports, the
22 department may contract with additional managed care health plans
23 to provide Medi-Cal services.

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

33 (i) The department may contract with existing managed care
34 health plans to provide or arrange for services under this section.
35 Notwithstanding any other law, the department may enter into the
36 contract without the need for a competitive bid process or other
37 contract proposal process, provided that the managed care health
38 plan provides written documentation that it meets all of the
39 qualifications and requirements of this section and Section
40 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.

SEC. 24. Section 14182.17 of the Welfare and Institutions Code, as added by Section 5 of Chapter 33 of the Statutes of 2012, 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 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 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 (1) Ensure timely and appropriate communications with
2 beneficiaries as follows:

3 (A) At least 90 days prior to enrollment, inform dual eligible
4 beneficiaries through a notice written at not more than a 6th-grade
5 reading level that includes, at a minimum, how the Medi-Cal
6 system of care will change, when the changes will occur, and who
7 they can contact for assistance with choosing a managed care health
8 plan or with problems they encounter.

9 (B) Develop and implement an outreach and education program
10 for beneficiaries to inform them of their enrollment options and
11 rights, including specific steps to work with consumer and
12 beneficiary community groups.

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

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

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

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

39 (G) Contingent upon available private or public funds other
40 than moneys from the General Fund, contract with

1 community-based, nonprofit consumer, or health insurance
2 assistance organizations with expertise and experience in assisting
3 dual eligible beneficiaries in understanding their health care
4 coverage options.

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

9 (i) Enrollment materials shall be made public at least 60 days
10 prior to the first mailing of notices to dual eligible beneficiaries,
11 and the department shall work with stakeholders to incorporate
12 public comment into the materials.

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

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

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

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

31 (I) The plan choices.

32 (II) Continuity of care provisions.

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

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

36 (vi) The enrollment contractor recognizes, in compliance with
37 existing statutes and regulations, authorized representatives,
38 including, but not limited to, a caregiver, family member,
39 conservator, or a legal services advocate, who is recognized by

1 any of the services or programs that the person is already receiving
2 or participating in.

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

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

9 (A) Assesses each new enrollee's risk level and needs by
10 performing a risk assessment process using means such as
11 telephonic, Web-based, or in-person communication, or review of
12 utilization and claims processing data, or by other means as
13 determined by the department, with a particular focus on
14 identifying those enrollees who may need long-term services and
15 supports. The risk assessment process shall be performed in
16 accordance with all applicable federal and state laws.

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

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

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

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

33 (F) Analyzes Medicare claims data for dual eligible beneficiaries
34 upon enrollment in a demonstration site pursuant to Section
35 14132.275 to provide an appropriate transition process for newly
36 enrolled beneficiaries who are prescribed Medicare Part D drugs
37 that are not on the demonstration site's formulary, as required
38 under the transition of care requirements for Medicare Part D
39 benefits as described in Chapters 6 and 14 of the Medicare
40 Managed Care Manual, published by CMS.

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

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

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

9 (A) Except for beneficiaries enrolled in the demonstration
10 project pursuant to Section 14132.275, forgo interference with a
11 beneficiary's choice of primary care physician under Medicare,
12 and not assign a full-benefit dual eligible beneficiary to a primary
13 care physician unless it is determined through the risk stratification
14 and assessment process that assignment is necessary, in order to
15 properly coordinate the care of the beneficiary or upon the
16 beneficiary's request.

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

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

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

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

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

38 (C) Develop care management and care coordination for the
39 beneficiary across the medical and long-term services and supports

1 care system, including transitions among levels of care and between
2 service locations.

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

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

11 (F) Consider behavioral health needs of beneficiaries and
12 coordinate those services with the county mental health department
13 as part of the beneficiary's care management plan when
14 appropriate.

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

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

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

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

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

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

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

39 (E) Contract with and assign patients to safety net and traditional
40 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:

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

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

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

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

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

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

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

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

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

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

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

37 ~~(8)~~

38 (1) Monitor the managed care health plans' performance and
39 accountability for provision of services, in addition to all other

1 statutory and contractual monitoring and oversight requirements,
2 by doing all of the following:

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

12 (B) Implement performance measures that are required as part
13 of the contract to provide quality assurance indicators for long-term
14 services and supports in quality assurance plans required under
15 the plans' contracts. These indicators shall include factors such as
16 affirmative member choice, increased independence, avoidance
17 of institutional care, and positive health outcomes. The department
18 shall develop these quality assurance indicators in consultation
19 with stakeholder groups.

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

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

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

35 (ii) Any routine financial examinations of managed care health
36 plans operating in the demonstration project authorized by Section
37 14132.275 that have been conducted and completed for the
38 previous calendar year by the Department of Managed Health Care
39 and the department.

40 (E)

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

5 ~~(9)~~

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

10 ~~(10)~~

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

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

15 (B) Together with the State Department of Social Services, the
16 California Department of Aging, and the Department of Managed
17 Health Care, in consultation with stakeholders, develop a
18 programmatic transition plan, and submit that plan to the
19 Legislature within 90 days of the effective date of this section. The
20 plan shall include, but is not limited to, the following components:

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

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

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

37 (iv) A description of how stakeholders were included in the
38 various phases of the planning process to formulate the transition
39 plan, and how their feedback shall be taken into consideration after
40 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

1 and beneficiary community groups described in clause (i),
2 consistent with the provisions of paragraph (1).

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

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

15 (IV) Develop a description of the benefits package available to
16 beneficiaries in order to assist them in plan selection and how they
17 may select and access services in the demonstration project's
18 assessment and care planning process.

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

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

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

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

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

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

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

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

16 (ix) Develop continuity of care procedures.

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

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

28 ~~(e) The Department of Managed Health Care shall, at minimum,~~
29 ~~monitor the plans on a quarterly basis to determine whether~~
30 ~~beneficiaries are able to receive timely access to primary and~~
31 ~~specialty care services, pursuant to Section 1367.03 of the Health~~
32 ~~and Safety Code.~~

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

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

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

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

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

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

21 *SEC. 25. Section 14183.6 of the Welfare and Institutions Code,*
22 *as amended by Section 6 of Chapter 33 of the Statutes of 2012, is*
23 *amended to read:*

24 14183.6. The department shall enter into an interagency
25 agreement with the Department of Managed Health Care to have
26 the Department of Managed Health Care, on behalf of the
27 department, conduct financial audits, medical surveys, and a review
28 of the provider networks of the managed care health plans
29 participating in the demonstration project, ~~and~~ *and the Medi-Cal*
30 *managed care expansion into rural counties, and to provide*
31 *consumer assistance to beneficiaries affected by the provisions of*
32 *Sections 14182.16 and 14182.17. The interagency agreement shall*
33 *be updated, as necessary, on an annual basis in order to maintain*
34 *functional clarity regarding the roles and responsibilities of these*
35 *core activities. The department shall not delegate its authority*
36 *under this division as the single state Medicaid agency to the*
37 *Department of Managed Health Care.*

38 *SEC. 26. Section 14186.2 of the Welfare and Institutions Code,*
39 *as added by Section 7 of Chapter 33 of the Statutes of 2012, is*
40 *amended to read:*

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

17 (2) HCBS plan benefits may be covered services that are
18 provided under managed care health plan contracts for beneficiaries
19 residing in counties participating in the demonstration authorized
20 under Section 14132.275, except for the exemptions provided for
21 in subdivision (c).

22 (3) Beneficiaries who are not mandatorily enrolled in a managed
23 care health plan pursuant to *paragraph (15) of subdivision (b) of*
24 *Section 14182* ~~or pursuant to the exemptions provided for in~~
25 ~~subdivision (c)~~ shall not be required to receive LTSS, ~~other than~~
26 ~~CBAS~~, through a managed care health plan.

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

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

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

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

39 (2) At the director's sole discretion, in consultation with
40 coordinating departments and stakeholders, the department may

1 determine and implement a phased-in enrollment approach that
2 may include the addition of Medi-Cal long-term services and
3 supports in a beneficiary's Medi-Cal managed care benefits
4 immediately upon implementation of this article in a specific
5 county, over a 12-month period, or other phased approach, but no
6 sooner than March 1, 2013.

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

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

13 (i) Except in counties with county organized health systems
14 operating pursuant to Article 2.8 (commencing with Section
15 14087.5), have other health coverage.

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

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

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

25 (B) Persons enrolled in the Program of All-Inclusive Care for
26 the Elderly (PACE) pursuant to Chapter 8.75 (commencing with
27 Section 14591), or a managed care organization licensed under
28 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
29 2.2 (commencing with Section 1340) of Division 2 of the Health
30 and Safety Code) that has previously contracted with the
31 department as a primary care case management plan pursuant to
32 Article 2.9 (commencing with Section 14088) of Chapter 7 to
33 provide services to beneficiaries who are HIV positive or who
34 have been diagnosed with AIDS.

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

36 ~~(D) Beneficiaries enrolled in a home- and community-based~~
37 ~~waiver that is a Medi-Cal benefit under Section 1915(c) of the~~
38 ~~federal Social Security Act (42 U.S.C. Sec. 1396n), except for~~
39 ~~persons enrolled in Community-Based Adult Services;~~

~~Multipurpose Senior Services Program services, or a Section 1915(c) waiver for developmentally disabled persons.~~

~~(E)~~

(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.

SEC. 27. Section 14301.1 of the Welfare and Institutions Code, as amended by Section 8 of Chapter 33 of the Statutes of 2012, 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.

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

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

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

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

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

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

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

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

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

34 (h) For the purposes of developing capitation rates through
35 implementation of this ratesetting methodology, Medi-Cal managed
36 care health plans shall provide the department with financial and
37 utilization data in a form and substance as deemed necessary by
38 the department to establish rates. This data shall be considered
39 proprietary and shall be exempt from disclosure as official
40 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.*

SEC. 28. Section 14301.2 of the Welfare and Institutions Code, as added by Section 9 of Chapter 33 of the Statutes of 2012, is amended to read:

14301.2. The director may defer *fee-for-service payments* or payments to Medi-Cal managed care health plans contracting 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), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing

1 with Section 14089) of this chapter, or Chapter 8 (commencing
2 with Section 14200) or Chapter 8.75 (commencing with Section
3 14591), the Senior Care Action Network Health Plan, and Medi-Cal
4 managed care health plan providers, as applicable, which are
5 payable to the plans during the final month of the 2012–13 state
6 fiscal year. This section may be implemented only to the extent
7 consistent with federal law.

8 *SEC. 29. Section 15912.1 of the Welfare and Institutions Code,*
9 *as added by Section 119 of Chapter 23 of the Statutes of 2012, is*
10 *amended to read:*

11 15912.1. (a) The department, in collaboration with the State
12 Department of Public Health, shall develop policies and guidance
13 on the transition of persons diagnosed with HIV/AIDS from federal
14 Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan
15 White Act) funded programs, pursuant to Section 131019 of the
16 Health and Safety Code, to the Low Income Health Program
17 (LIHP) pursuant to ~~Part 3.6 (commencing with Section 15909)~~
18 *this part*. These policies and guidance shall be provided to local
19 LIHPs, federal Ryan White Act providers, and to persons receiving
20 services pursuant to the federal Ryan White Act, as applicable.
21 Guidance shall include, but not be limited to, operational processes
22 and procedures supporting the transition of persons receiving
23 services pursuant to the federal Ryan White Act in order to
24 minimize disruption of access to and availability of care and
25 services.

26 (b) The department, in collaboration with the State Department
27 of Public Health, shall consult with stakeholders, including
28 administrators, advocates, providers, and persons receiving services
29 pursuant to the federal Ryan White Act, to obtain advice in forming
30 the policy decisions regarding the transition of persons receiving
31 services pursuant to the federal Ryan White Act to the local LIHPs.

32 (c) *Notwithstanding any other law, for the purpose of*
33 *implementing LIHP, pursuant to this part, the State Department*
34 *of Public Health may share relevant data related to a beneficiary's*
35 *enrollment in federal Ryan White Act funded programs who may*
36 *be eligible for LIHP services with the participating entity, as*
37 *defined in Section 15909.1, operating a LIHP, and the participating*
38 *entity may share relevant data relating to persons diagnosed with*
39 *HIV/AIDS with the State Department of Public Health.*

1 (1) *The information provided by the State Department of Public*
2 *Health pursuant to this section shall not be further disclosed by a*
3 *participating entity, as defined in Section 15909.1, operating a*
4 *LIHP, except to any of the following:*

5 (A) *The person to whom the information pertains or the*
6 *designated representative of the person.*

7 (B) *The health care provider that provides HIV/AIDS care to*
8 *the person to whom the information pertains.*

9 (C) *The Office of AIDS within the State Department of Public*
10 *Health.*

11 (2) *Information shared pursuant to this section is subject to the*
12 *confidentiality protections of subdivisions (d) and (e) of Section*
13 *121025 of the Health and Safety Code.*

14 SEC. 30. *The sum of one thousand dollars (\$1,000) is hereby*
15 *appropriated from the General Fund to the State Department of*
16 *Health Care Services for administration.*

17 SEC. 31. *This act is a bill providing for appropriations related*
18 *to the Budget Bill within the meaning of subdivision (e) of Section*
19 *12 of Article IV of the California Constitution, has been identified*
20 *as related to the budget in the Budget Bill, and shall take effect*
21 *immediately.*

22 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~
23 ~~changes relating to the Budget Act of 2012.~~