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## *California State Senate*

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ON  
BUDGET AND FISCAL REVIEW

ROOM 5019, STATE CAPITOL  
SACRAMENTO, CA 95814

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### Agenda

**June 17, 2013**  
**11:00 a.m., Room 4203**

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# INFORMATIONAL HEARING - COORDINATED CARE INITIATIVE

**SENATE COMMITTEE ON BUDGET AND FISCAL REVIEW**  
*Mark Leno, Chair*

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Bill No: SB 94  
Author: Committee on Budget and Fiscal Review  
As Amended: June 13, 2013  
Consultant: Michelle Baass & Jennifer Troia  
Fiscal: Yes

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**Subject:** Budget Act of 2013: Coordinated Care Initiative (CCI)

**Summary:** This bill changes existing law regarding the Coordinated Care Initiative (CCI) and delinks CCI components to allow the mandatory enrollment of Medi-Cal and Medicare beneficiaries (dual eligibles) into Medi-Cal managed care, the integration of long-term supports and services into managed care plans, and the commencement of the In-Home Supportive Services (IHSS) Statewide Public Authority, to proceed separately from the CCI Duals Demonstration Project (now called Cal MediConnect).

**Background:** The 2012 budget authorized the Coordinated Care Initiative (CCI), by which persons eligible for both Medicare and Medi-Cal (dual eligibles) would receive medical, behavioral, long-term supports and services, and home- and community-based services coordinated through a single health plan in eight demonstration counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

CCI contains three key components (1) Cal MediConnect - Individuals who are eligible for both Medi-Cal and Medicare (dual eligibles) receive all of their services through a managed care plan, (2) Mandatory enrollment of dual eligibles into Medi-Cal managed care, and (3) Integration of long-term supports and services into managed care. Current law sets forth certain circumstances that would render these components inoperative and links these components together so that each component cannot function or operate exclusive of the other.

**Proposed Law:** This bill includes provisions that would:

- 1) Delink the operation of the duals demonstration project (Cal MediConnect) from mandatory enrollment of duals into Medi-Cal managed care, the integration of Medi-Cal long-term supports and

services into managed care plans, and the commencement of the In-Home Supportive Services (IHSS) Statewide Public Authority.

- 2) Require the Department of Health Care Services to offer Medicare D-SNP contracts to existing D-SNP plans in 2014. Additionally, in 2014, beneficiaries enrolled in a Medicare Advantage or D-SNP plan operating in a CCI county shall be exempt from passive enrollment into Cal MediConnect.
- 3) Provide for health plan risk corridors for populations and services that are part of the CCI.
- 4) Require the Department of Health Care Services, commencing August 1, 2013, to convene stakeholders at least quarterly to review progress on CCI and make recommendations to the department and Legislature for the duration of CCI.
- 5) Delete previous requirements (i.e., the poison pill) regarding the ongoing operation of CCI.
- 6) Specify that if, at least 30 days prior to the enrollment of beneficiaries into the CCI, the Director of Finance estimates that CCI would not generate net General Fund savings, then the CCI should become inoperative July 1, 2014.
- 7) Specify that CCI counties include the counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
- 8) Declare that, if the LTSS portion of CCI is implemented, the provisions of existing law with respect to the rights of recipients to select, direct, supervise, and terminate IHSS providers, and the obligations of health plans to enter into memorandums of understanding with county agencies that would continue to perform specified functions and responsibilities related to the IHSS program, would remain in effect.
- 9) Delete a provision of existing law that would have eliminated an existing County IHSS Maintenance of Effort (MOE) requirement if the Duals Demonstration project ceased to be operative. At the same time, the MOE would still become inoperative if the larger CCI becomes inoperative.
- 10) Make additional, technical changes.

**Introduced by Committee on Budget and Fiscal Review**

January 10, 2013

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*An act relating to the Budget Act of 2013. An act to amend Section 6253.2 of the Government Code, to amend Sections 10101.1, 12300.7, 12306, 12306.1, 12306.15, 14182.16, 14182.17, 14186, 14186.1, 14186.2, 14186.3, 14186.36, and 14186.4 of, to amend and add Sections 14132.275, 14183.6 and 14301.1, of, and to add Sections 14132.277, 14182.18, and 14186.11 to, the Welfare and Institutions Code, to repeal Section 10 of Chapter 33 of the Statutes of 2012, and to repeal Sections 15, 16, and 17 of Chapter 45 of the Statutes of 2012, relating to Medi-Cal, and making an appropriation therefor, to take effect immediately, bill related to the budget.*

LEGISLATIVE COUNSEL'S DIGEST

SB 94, as amended, Committee on Budget and Fiscal Review. ~~Budget Act of 2013.~~ *Medi-Cal: managed care: long-term services and supports: in-home supportive services.*

*(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires the department to seek federal approval to establish a demonstration project as described in law pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination thereof. Existing law provides that if the department has not received by February 1, 2013, federal approval, or notification indicating pending approval, of a mutual*

*ratesetting process, shared federal savings, and a 6-month enrollment period in the demonstration project, effective March 1, 2013, Chapter 45 of the Statutes of 2012, and specified provisions of Chapter 33 of the Statutes of 2012, are inoperative, as provided. Chapter 33 of the Statutes of 2012, among other things, requires that Medi-Cal beneficiaries who have dual eligibility in the Medi-Cal and Medicare programs be assigned as mandatory enrollees into managed care plans in counties participating in the demonstration project, and requires that no sooner than March 1, 2013, all Medi-Cal long-term services and supports, which includes Multipurpose Senior Services Program (MSSP) services, be covered under managed care plan contracts and only available through managed care plans to beneficiaries residing in counties participating in the demonstration project. Chapter 45 of the Statutes of 2012, among other things, establishes the California In-Home Supportive Services Authority (Statewide Authority), and provides that the In-Home Supportive Services Program is a Medi-Cal benefit available through managed care health care plans in specified counties, as specified. Existing law provides that no sooner than March 1, 2103, the Statewide Authority shall assume specified responsibilities in a county or city and county upon notification by the Director of Health Care Services that the enrollment of eligible Medi-Cal beneficiaries described in specified provisions of law has been completed in that county or city and county.*

*This bill would instead require enrollment of eligible Medi-Cal beneficiaries into managed care pursuant to the demonstration project or other specified provisions, including managed care for long-term services and supports, as one of the conditions that would be required to be completed before the Statewide Authority assumes the specified responsibilities. The bill would modify the provisions governing when MSSP becomes a Medi-Cal benefit only through managed care health plans, as prescribed. The bill would delete the provision authorizing the Director of Health Care Services to forgo the provision of long-term services and supports only through managed care, in its entirety or partially, if and to the extent the director determines that the quality of care for managed care beneficiaries, efficiency, or cost-effectiveness of the program would be jeopardized. The bill would require the State Department of Health Care Services to convene quarterly meetings with stakeholders to make recommendations regarding the Coordinated Care Initiative, as specified. The bill would require that in Coordinated Care Initiative Counties for managed care health plans providing*

*long-term services and supports, the department shall include in its contract with those plans risk corridors to provide protections against either significant overpayment or significant underpayments. The bill would also repeal the provisions conditioning the operation of Chapter 45 of the Statutes of 2012 and specified provisions of Chapter 33 of the Statutes of 2012 on receipt of federal approval or notification of pending approval by February 1, 2013. The bill would instead condition implementation of the Coordinated Care Initiative, as defined, on whether the Director of Finance estimates that the Coordinated Care Initiative will generate net General Fund savings, as specified. The bill would also make other related technical, nonsubstantive changes.*

*(2) The bill would appropriate the amount of \$500,000 from the General Fund to the State Department of Health Care Services for the Coordinated Care Initiative for purposes of notifying dual eligible beneficiaries and providers regarding the provisions of this act, and would provide that those funds be available for encumbrance and expenditure until June 30, 2014.*

*(3) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.*

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2013.~~

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

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

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

4 6253.2. (a) Notwithstanding any other provision of this chapter  
5 to the contrary, information regarding persons paid by the state to  
6 provide in-home supportive services pursuant to Article 7  
7 (commencing with Section 12300) of Chapter 3 of Part 3 of  
8 Division 9 of the Welfare and Institutions Code, or services  
9 provided pursuant to Section 14132.95, 14132.952, or 14132.956  
10 of the Welfare and Institutions Code, ~~shall~~ is not ~~be~~ subject to  
11 public disclosure pursuant to this chapter, except as provided in  
12 subdivision (b).

13 (b) Copies of names, addresses, and telephone numbers of  
14 persons described in subdivision (a) shall be made available, upon

1 request, to an exclusive bargaining agent and to any labor  
2 organization seeking representation rights pursuant to Section  
3 12301.6 or 12302.25 of the Welfare and Institutions Code or the  
4 In-Home Supportive Services Employer-Employee Relations Act  
5 (Title 23 (commencing with Section 110000)). This information  
6 shall not be used by the receiving entity for any purpose other than  
7 the employee organizing, representation, and assistance activities  
8 of the labor organization.

9 (c) This section ~~shall apply~~ *applies* solely to individuals who  
10 provide services under the In-Home Supportive Services Program  
11 (Article 7 (commencing with Section 12300) of Chapter 3 of Part  
12 3 of Division 9 of the Welfare and Institutions Code), the Personal  
13 Care Services Program pursuant to Section 14132.95 of the Welfare  
14 and Institutions Code, the In-Home Supportive Services Plus  
15 Option pursuant to Section 14132.952 of the Welfare and  
16 Institutions Code, or the Community First Choice Option pursuant  
17 to Section 14132.956 of the Welfare and Institutions Code.

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

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

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

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

32 6253.2. (a) Notwithstanding any other provision of this chapter  
33 to the contrary, information regarding persons paid by the state to  
34 provide in-home supportive services pursuant to Article 7  
35 (commencing with Section 12300) of Chapter 3 of Part 3 of  
36 Division 9 of the Welfare and Institutions Code or personal care  
37 services pursuant to Section 14132.95 of the Welfare and  
38 Institutions Code, ~~shall~~ *is not be* subject to public disclosure  
39 pursuant to this chapter, except as provided in subdivision (b).

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

11 (c) This section ~~shall apply~~ *applies* solely to individuals who  
12 provide services under the In-Home Supportive Services Program  
13 (Article 7 (commencing with Section 12300) of Chapter 3 of Part  
14 3 of Division 9 of the Welfare and Institutions Code) or the  
15 Personal Care Services Program pursuant to Section 14132.95 of  
16 the Welfare and Institutions Code.

17 (d) Nothing in this section is intended to alter or shall be  
18 interpreted to alter the rights of parties under the  
19 Meyers-Milias-Brown Act (Chapter 10 (commencing with Section  
20 3500) of Division 4) or any other labor relations law.

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

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

27 *SEC. 3. [Reserved]*

28 *SEC. 4. [Reserved]*

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

32 10101.1. (a) For the 1991–92 fiscal year and each fiscal year  
33 thereafter, the state’s share of the costs of the county services block  
34 grant and the in-home supportive services administration  
35 requirements shall be 70 percent of the actual nonfederal  
36 expenditures or the amount appropriated by the Legislature for  
37 that purpose, whichever is less.

38 (b) Federal funds received under Title 20 of the federal Social  
39 Security Act (42 U.S.C. Sec. 1397 et seq.) and appropriated by the  
40 Legislature for the county services block grant and the in-home



1 supportive services administration shall be considered part of the  
2 state share of cost and not part of the federal expenditures for this  
3 purpose.

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

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

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

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

19 10101.1. (a) For the 1991–92 fiscal year and each fiscal year  
20 thereafter, the state's share of the costs of the county services block  
21 grant and the in-home supportive services administration  
22 requirements shall be 70 percent of the actual nonfederal  
23 expenditures or the amount appropriated by the Legislature for  
24 that purpose, whichever is less.

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

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

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

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

39 12300.7. (a) No sooner than March 1, 2013, the California  
40 In-Home Supportive Services Authority shall assume the

1 responsibilities set forth in Title 23 (commencing with Section  
2 110000) of the Government Code in a county or city and county  
3 upon notification by the Director of Health Care Services that the  
4 enrollment of eligible Medi-Cal beneficiaries described in Sections  
5 ~~14132.275~~, *Section 14132.275* or 14182.16, ~~and 14182.17~~ or  
6 *Article 5.7 (commencing with Section 14186) of Chapter 7* has  
7 been completed in that county or city and county.

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

11 (1) Have the entity that performed functions set forth in the  
12 county ordinance or contract in effect at the time of the notification  
13 pursuant to subdivision (a) and established pursuant to Section  
14 12301.6 continue to perform those functions, excluding subdivision  
15 (c) of that section.

16 (2) Assume the functions performed by the entity, at the time  
17 of the notification pursuant to subdivision (a), pursuant to Section  
18 12301.6, excluding subdivision (c) of that section.

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

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

26 12306. (a) The state and counties shall share the annual cost  
27 of providing services under this article as specified in this section.

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

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

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

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

19 (e) For the period during which Section 12306.15 is operative,  
20 each county's share of the costs of providing services pursuant to  
21 this article specified in subdivisions (b) and (c) shall remain, but  
22 the County IHSS Maintenance of Effort pursuant to Section  
23 12306.15 shall be in lieu of that share.

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

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

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

33 12306. (a) The state and counties shall share the annual cost  
34 of providing services under this article as specified in this section.

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

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

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

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

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

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

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

35 12306.1. (a) When any increase in provider wages or benefits  
36 is negotiated or agreed to by a public authority or nonprofit  
37 consortium under Section 12301.6, then the county shall use  
38 county-only funds to fund both the county share and the state share,  
39 including employment taxes, of any increase in the cost of the  
40 program, unless otherwise provided for in the annual Budget Act

1 or appropriated by statute. No increase in wages or benefits  
2 negotiated or agreed to pursuant to this section shall take effect  
3 unless and until, prior to its implementation, the department has  
4 obtained the approval of the State Department of Health Care  
5 Services for the increase pursuant to a determination that it is  
6 consistent with federal law and to ensure federal financial  
7 participation for the services under Title XIX of the federal Social  
8 Security Act, and unless and until all of the following conditions  
9 have been met:

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

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

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

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

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

37 (2) The state shall participate as provided in subdivision (c) in  
38 a total of wages and individual health benefits up to nine dollars  
39 and ten cents (\$9.10) per hour, if wages have reached at least seven  
40 dollars and fifty cents (\$7.50) per hour. Counties shall determine,

1 pursuant to the collective bargaining process provided for in  
2 subdivision (c) of Section 12301.6, what portion of the nine dollars  
3 and ten cents (\$9.10) per hour shall be used to fund wage increases  
4 above seven dollars and fifty cents (\$7.50) per hour or individual  
5 health benefit increases, or both. This paragraph shall be operative  
6 for the 2001–02 fiscal year and each fiscal year thereafter, unless  
7 otherwise provided in paragraphs (3), (4), and (5).

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

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

35 (5) The state shall participate as provided in subdivision (c) in  
36 a total cost of wages and individual health benefits up to twelve  
37 dollars and ten cents (\$12.10) per hour, if wages have reached at  
38 least seven dollars and fifty cents (\$7.50) per hour. Counties shall  
39 determine, pursuant to the collective bargaining process provided  
40 for in subdivision (c) of Section 12301.6, what portion of the

1 twelve dollars and ten cents (\$12.10) per hour shall be used to fund  
2 wage increases above seven dollars and fifty cents (\$7.50) per hour  
3 or individual health benefit increases, or both. This paragraph shall  
4 be operative commencing with the next state fiscal year for which  
5 the May Revision forecast of General Fund revenue, excluding  
6 transfers, exceeds by at least 5 percent, the most current estimate  
7 of revenues, excluding transfers, for the year in which paragraph  
8 (4) became operative.

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

15 (2) For purposes of certifications under paragraph (1), the  
16 General Fund revenue forecast, excluding transfers, that is used  
17 for the relevant fiscal year shall be calculated in a manner that is  
18 consistent with the definition of General Fund revenues, excluding  
19 transfers, that was used by the Department of Finance in the  
20 2000–01 Governor’s Budget revenue forecast as reflected on  
21 Schedule 8 of the Governor’s Budget.

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

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

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

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

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

7 12306.1. (a) When any increase in provider wages or benefits  
8 is negotiated or agreed to by a public authority or nonprofit  
9 consortium under Section 12301.6, then the county shall use  
10 county-only funds to fund both the county share and the state share,  
11 including employment taxes, of any increase in the cost of the  
12 program, unless otherwise provided for in the annual Budget Act  
13 or appropriated by statute. No increase in wages or benefits  
14 negotiated or agreed to pursuant to this section shall take effect  
15 unless and until, prior to its implementation, the department has  
16 obtained the approval of the State Department of Health Care  
17 Services for the increase pursuant to a determination that it is  
18 consistent with federal law and to ensure federal financial  
19 participation for the services under Title XIX of the federal Social  
20 Security Act, and unless and until all of the following conditions  
21 have been met:

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

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

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

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



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

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

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

34 (4) The state shall participate as provided in subdivision (c) in  
35 a total of wages and individual health benefits up to eleven dollars  
36 and ten cents (\$11.10) per hour, if wages have reached at least  
37 seven dollars and fifty cents (\$7.50) per hour. Counties shall  
38 determine, pursuant to the collective bargaining process provided  
39 for in subdivision (c) of Section 12301.6, what portion of the eleven  
40 dollars and ten cents (\$11.10) per hour shall be used to fund wage

1 increases or individual health benefits, or both. This paragraph  
2 shall be operative commencing with the next state fiscal year for  
3 which the May Revision forecast of General Fund revenue,  
4 excluding transfers, exceeds by at least 5 percent, the most current  
5 estimate of revenues, excluding transfers, for the year in which  
6 paragraph (3) became operative.

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

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

27 (2) For purposes of certifications under paragraph (1), the  
28 General Fund revenue forecast, excluding transfers, that is used  
29 for the relevant fiscal year shall be calculated in a manner that is  
30 consistent with the definition of General Fund revenues, excluding  
31 transfers, that was used by the Department of Finance in the  
32 2000–01 Governor’s Budget revenue forecast as reflected on  
33 Schedule 8 of the Governor’s Budget.

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

1 as provided under paragraphs (2) to (5), inclusive, of subdivision  
2 (d).

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

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

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

11 12306.15. (a) Commencing July 1, 2012, all counties shall  
12 have a County IHSS Maintenance of Effort (MOE). In lieu of  
13 paying the nonfederal share of IHSS costs as specified in Sections  
14 10101.1, 12306, and 12306.1, counties shall pay the County IHSS  
15 MOE.

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

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

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

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

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

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

39 (3) (A) Notwithstanding paragraphs (1) and (2), in fiscal years  
40 when the combined total of 1991 realignment revenues received

1 pursuant to Sections 11001.5, 6051.2, and 6201.2 of the Revenue  
2 and Taxation Code, for the prior fiscal year is less than the  
3 combined total received for the next prior fiscal year, the inflation  
4 factor shall be zero.

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

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

16 (1) (A) If the department approves the rates and other economic  
17 terms for a locally negotiated, mediated, or imposed increase in  
18 the provider wages, health benefits, or other economic terms  
19 pursuant to Section 12306.1 and paragraph (3), the state shall pay  
20 65 percent, and the affected county shall pay 35 percent, of the  
21 nonfederal share of the cost increase in accordance with  
22 subparagraph (B).

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

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

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

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

8 (3) In addition to the rate approval requirements in Section  
 9 12306.1, it shall be presumed by the department that locally  
 10 negotiated rates and other economic terms within the following  
 11 limits are approved:

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

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

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

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

29 ~~(g) If the demonstration project and the responsibilities of the~~  
 30 ~~Statewide Authority become inoperative pursuant to Section 15,~~  
 31 ~~16, or 17 of the act adding this section on a date other than July 1,~~  
 32 ~~this section shall become inoperative on the first day of the~~  
 33 ~~following state fiscal year.~~

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

36 14132.275. (a) The department shall seek federal approval to  
 37 establish the demonstration project described in this section  
 38 pursuant to a Medicare or a Medicaid demonstration project or  
 39 waiver, or a combination thereof. Under a Medicare demonstration,  
 40 the department may contract with the federal Centers for Medicare

1 and Medicaid Services (CMS) and demonstration sites to operate  
2 the Medicare and Medicaid benefits in a demonstration project  
3 that is overseen by the state as a delegated Medicare benefit  
4 administrator, and may enter into financing arrangements with  
5 CMS to share in any Medicare program savings generated by the  
6 demonstration project.

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

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

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

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

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

4 (4) “Dual eligible beneficiary” means an individual 21 years of  
5 age or older who is enrolled for benefits under Medicare Part A  
6 (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C.  
7 Sec. 1395j et seq.) and is eligible for medical assistance under the  
8 Medi-Cal State Plan.

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

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

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

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

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

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

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

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

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

38 (7) Promote a system that is both sustainable and person and  
39 family centered by providing dual eligible beneficiaries with timely  
40 access to appropriate, coordinated health care services and

1 community resources that enable them to attain or maintain  
2 personal health goals.

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

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

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

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

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

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

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

37 (B) Be in good financial standing and meet licensure  
38 requirements under the Knox-Keene Health Care Service Plan Act  
39 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division  
40 2 of the Health and Safety Code), except for county organized



1 health system plans that are exempt from licensure pursuant to  
2 Section 14087.95.

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

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

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

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

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

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

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

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

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

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

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

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

1 (9) To the extent permissible under federal requirements,  
2 implementation of the provisions of Sections 14182.16 and  
3 14182.17 that are applicable to beneficiaries simultaneously eligible  
4 for full-scope benefits under Medi-Cal and the Medicare Program.

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

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

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

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

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

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

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

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

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

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

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

6 (k) The director may enter into exclusive or nonexclusive  
7 contracts on a bid or negotiated basis and may amend existing  
8 managed care contracts to provide or arrange for services provided  
9 under this section. Contracts entered into or amended pursuant to  
10 this section shall be exempt from the provisions of Chapter 2  
11 (commencing with Section 10290) of Part 2 of Division 2 of the  
12 Public Contract Code and Chapter 6 (commencing with Section  
13 14825) of Part 5.5 of Division 3 of Title 2 of the Government  
14 Code.

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

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

34 (C) (i) Persons meeting requirements for the Program of  
35 All-Inclusive Care for the Elderly (PACE) pursuant to Chapter  
36 8.75 (commencing with Section 14591) or a managed care  
37 organization licensed under the Knox-Keene Health Care Service  
38 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)  
39 of Division 2 of the Health and Safety Code) that has previously  
40 contracted with the department as a primary care case management

1 plan pursuant to Article 2.9 (commencing with Section 14088) of  
2 Chapter 7 to provide services to beneficiaries who are HIV positive  
3 or who have been diagnosed with AIDS may select either of these  
4 managed care health plans for their Medicare and Medi-Cal benefits  
5 if one is available in that county.

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

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

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

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

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

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

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

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

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

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

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

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

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

36 (vi) The beneficiary resides in one of the Veterans' Homes of  
37 California, as described in Chapter 1 (commencing with Section  
38 1010) of Division 5 of the Military and Veterans Code.

39 (B) (i) Beneficiaries who have been diagnosed with HIV/AIDS  
40 may opt out of the demonstration project at the beginning of any

1 month. The State Department of Public Health may share relevant  
2 data relating to a beneficiary's enrollment in the AIDS Drug  
3 Assistance Program with the department, and the department may  
4 share relevant data relating to HIV-positive beneficiaries with the  
5 State Department of Public Health.

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

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

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

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

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

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

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

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

12 (m) Notwithstanding Section 10231.5 of the Government Code,  
 13 the department shall conduct an evaluation, in partnership with  
 14 CMS, to assess outcomes and the experience of dual eligibles in  
 15 these demonstration sites and shall provide a report to the  
 16 Legislature after the first full year of demonstration operation, and  
 17 annually thereafter. A report submitted to the Legislature pursuant  
 18 to this subdivision shall be submitted in compliance with Section  
 19 9795 of the Government Code. The department shall consult with  
 20 stakeholders regarding the scope and structure of the evaluation.

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

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

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

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

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

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

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

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

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

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

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

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

38 (q) (1) Beginning with the May Revision to the 2013–14  
39 Governor's Budget, and annually thereafter, the department shall



1 report to the Legislature on the enrollment status, quality measures,  
2 and state costs of the actions taken pursuant to this section.

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

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

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

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

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

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

6 14132.275. (a) *The department shall seek federal approval to*  
7 *establish pilot projects described in this section pursuant to a*  
8 *Medicare or a Medicaid demonstration project or waiver, or a*  
9 *combination thereof. Under a Medicare demonstration, the*  
10 *department may operate the Medicare component of a pilot project*  
11 *as a delegated Medicare benefit administrator, and may enter into*  
12 *financing arrangements with the federal Centers for Medicare and*  
13 *Medicaid Services to share in any Medicare program savings*  
14 *generated by the operation of any pilot project.*

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

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

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

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

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

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

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

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

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

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

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

29     (g) *Services under Section 14132.95 or 14132.952, or Article*  
30 *7 (commencing with Section 12300) of Chapter 3 that are provided*  
31 *under the pilot projects established by this section shall be provided*  
32 *through direct hiring of personnel, contract, or establishment of*  
33 *a public authority or nonprofit consortium, in accordance with,*  
34 *and subject to, Section 12302 or 12301.6, as applicable.*

35     (h) *Notwithstanding any other provision of state law, the*  
36 *department may require that dual eligibles be assigned as*  
37 *mandatory enrollees into managed care plans established or*  
38 *expanded as part of a pilot project established under this section.*  
39 *Mandatory enrollment in managed care for dual eligibles shall be*  
40 *applicable to the beneficiary's Medi-Cal benefits only. Dual*

1 eligibles shall have the option to enroll in a Medicare Advantage  
2 special needs plan (SNP) offered by the managed care plan  
3 established or expanded as part of a pilot project established  
4 pursuant to subdivision (e). To the extent that mandatory  
5 enrollment is required, any requirement of the department and the  
6 health plans, and any requirement of continuity of care protections  
7 for enrollees, as specified in Section 14182, shall be applicable to  
8 this section. Dual eligibles shall have the option to forgo receiving  
9 Medicare benefits under a pilot project. Nothing in this section  
10 shall be interpreted to reduce benefits otherwise available under  
11 the Medi-Cal program or the Medicare Program.

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

15 (j) Persons meeting requirements for the Program of  
16 All-Inclusive Care for the Elderly (PACE) pursuant to Chapter  
17 8.75 (commencing with Section 14591), may select a PACE plan  
18 if one is available in that county.

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

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

31 (m) Notwithstanding Chapter 3.5 (commencing with Section  
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
33 the department may implement, interpret, or make specific this  
34 section and any applicable federal waivers and state plan  
35 amendments by means of all-county letters, plan letters, plan or  
36 provider bulletins, or similar instructions, without taking  
37 regulatory action. Prior to issuing any letter or similar instrument  
38 authorized pursuant to this section, the department shall notify  
39 and consult with stakeholders, including advocates, providers,  
40 and beneficiaries. The department shall notify the appropriate

1 *policy and fiscal committees of the Legislature of its intent to issue*  
2 *instructions under this section at least five days in advance of the*  
3 *issuance.*

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

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

9 *14132.277. (a) For purposes of this section, the following*  
10 *definitions shall apply:*

11 *(1) “Coordinated Care Initiative county” means the Counties*  
12 *of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San*  
13 *Diego, San Mateo, and Santa Clara, and any other county*  
14 *identified in Appendix 3 of the memorandum of understanding*  
15 *between the state and the Centers for Medicare and Medicaid*  
16 *Services Regarding A Federal-State Partnership to Test a*  
17 *Capitated Financial Alignment Model for Medicare-Medicaid*  
18 *Enrollees, inclusive of all amendments, as authorized by Section*  
19 *14132.275.*

20 *(2) “D-SNP plan” means a Medicare Advantage Special Needs*  
21 *Plan.*

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

25 *(b) For calendar year 2014, the department shall offer D-SNP*  
26 *contracts to existing D-SNP plans to continue to provide benefits*  
27 *to their enrollees in their service areas as approved on January*  
28 *1, 2013. The director may include in any D-SNP contract*  
29 *provisions requiring that the D-SNP plan do the following:*

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

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

36 *(c) In Coordinated Care Initiative counties, Medicare Advantage*  
37 *Plans and D-SNP plans may continue to enroll beneficiaries in*  
38 *2014. In the 2014 calendar year, beneficiaries enrolled in a*  
39 *Medicare Advantage or D-SNP plan operating in a Coordinated*  
40 *Care Initiative county shall be exempt from the enrollment*

1 provisions of subparagraph (A) of paragraph (1) of subdivision  
2 (l) of Section 14132.275. Those beneficiaries may at any time  
3 voluntarily choose to disenroll from their Medicare Advantage or  
4 D-SNP plan and enroll in a demonstration site operating pursuant  
5 to subdivision (g) of Section 14132.275. If a beneficiary chooses  
6 to do so, that beneficiary may subsequently disenroll from the  
7 demonstration site and return to fee-for-service Medicare or to a  
8 D-SNP plan or Medicare Advantage plan.

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

11 14182.16. (a) The department shall require Medi-Cal  
12 beneficiaries who have dual eligibility in Medi-Cal and the  
13 Medicare Program to be assigned as mandatory enrollees into new  
14 or existing Medi-Cal managed care health plans for their Medi-Cal  
15 benefits in ~~counties participating in the demonstration project~~  
16 ~~pursuant to Section 14132.275 Coordinated Care Initiative~~  
17 ~~counties.~~

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

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

23 ~~(1)~~

24 (2) “Dual eligible beneficiary” means an individual 21 years of  
25 age or older who is enrolled for benefits under Medicare Part A  
26 (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec.  
27 1395j et seq.), or both, and is eligible for medical assistance under  
28 the Medi-Cal State Plan.

29 ~~(2)~~

30 (3) “Full-benefit dual eligible beneficiary” means an individual  
31 21 years of age or older who is eligible for benefits under Medicare  
32 Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C.  
33 Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec.  
34 1395w-101), and is eligible for medical assistance under the  
35 Medi-Cal State Plan.

36 ~~(3)~~

37 (4) “Managed care health plan” means an individual,  
38 organization, or entity that enters into a contract with the  
39 department pursuant to Article 2.7 (commencing with Section  
40 14087.3), Article 2.81 (commencing with Section 14087.96), or

1 Article 2.91 (commencing with Section 14089), of this chapter,  
2 or Chapter 8 (commencing with Section 14200).

3 ~~(4)~~

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

11 ~~(5)~~

12 (6) “Out-of-network Medi-Cal provider” means a health care  
13 provider that does not have an existing contract with the  
14 beneficiary’s managed care health plan or its subcontractors.

15 ~~(6)~~

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

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

27 (A) Except in counties with county organized health systems  
28 operating pursuant to Article 2.8 (commencing with Section  
29 14087.5), the beneficiary has other health coverage.

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

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

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

37 (E) The beneficiary resides in one of the Veterans Homes of  
38 California, as described in Chapter 1 (commencing with Section  
39 1010) of Division 5 of the Military and Veterans Code.

1 (F) The beneficiary is enrolled in any entity with a contract with  
2 the department pursuant to Chapter 8.75 (commencing with Section  
3 14591).

4 (G) The beneficiary is enrolled in a managed care organization  
5 licensed under the Knox-Keene Health Care Service Plan Act of  
6 1975 (Chapter 2.2 (commencing with Section 1340) of Division  
7 2 of the Health and Safety Code) that has previously contracted  
8 with the department as a primary care case management plan  
9 pursuant to Article 2.9 (commencing with Section 14088) of  
10 Chapter 7.

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

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

17 (e) At the director's sole discretion, in consultation with  
18 stakeholders, the department may determine and implement a  
19 phased-in enrollment approach that may include Medi-Cal  
20 beneficiary enrollment into managed care health plans immediately  
21 upon implementation of this section in a specific county, over a  
22 12-month period, or other phased approach. The phased-in  
23 enrollment shall commence no sooner than March 1, 2013, and  
24 not until all necessary federal approvals have been obtained.

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

29 (g) Except in a county where Medi-Cal services are provided  
30 by a county organized health system, and notwithstanding any  
31 other law, in any county in which fewer than two existing managed  
32 health care plans contract with the department to provide Medi-Cal  
33 services under this chapter that are available to dual eligible  
34 beneficiaries, including long-term services and supports, the  
35 department may contract with additional managed care health plans  
36 to provide Medi-Cal services.

37 (h) For partial-benefit dual eligible beneficiaries, the department  
38 shall inform these beneficiaries of their rights to continuity of care  
39 from out-of-network Medi-Cal providers pursuant to subparagraph  
40 (G) of paragraph (5) of subdivision (d) of Section 14182.17, and



1 that the need for medical exemption criteria applied to counties  
2 operating under Chapter 4.1 (commencing with Section 53800) of  
3 Subdivision 1 of Division 3 of Title 22 of the California Code of  
4 Regulations may not be necessary to continue receiving Medi-Cal  
5 services from an out-of-network provider.

6 (i) The department may contract with existing managed care  
7 health plans to provide or arrange for services under this section.  
8 Notwithstanding any other law, the department may enter into the  
9 contract without the need for a competitive bid process or other  
10 contract proposal process, provided that the managed care health  
11 plan provides written documentation that it meets all of the  
12 qualifications and requirements of this section and Section  
13 14182.17.

14 (j) The development of capitation rates for managed care health  
15 plan contracts shall include the analysis of data specific to the dual  
16 eligible population. For the purposes of developing capitation rates  
17 for payments to managed care health plans, the department shall  
18 require all managed care health plans, including existing managed  
19 care health plans, to submit financial, encounter, and utilization  
20 data in a form, at a time, and including substance as deemed  
21 necessary by the department. Failure to submit the required data  
22 shall result in the imposition of penalties pursuant to Section  
23 14182.1.

24 (k) Persons meeting participation requirements for the Program  
25 of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter  
26 8.75 (commencing with Section 14591) may select a PACE plan  
27 if one is available in that county.

28 (l) Except for dual eligible beneficiaries participating in the  
29 demonstration project pursuant to Section 14132.275, persons  
30 meeting the participation requirements in effect on January 1,  
31 2010, for a Medi-Cal primary case management plan in operation  
32 on that date, may select that primary care case management plan  
33 or a successor health care plan that is licensed pursuant to the  
34 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2  
35 (commencing with Section 1340) of Division 2 of the Health and  
36 Safety Code) to provide services within the same geographic area  
37 that the primary care case management plan served on January 1,  
38 2010.

39 (m) The department may implement an intergovernmental  
40 transfer arrangement with a public entity that elects to transfer

1 public funds to the state to be used solely as the nonfederal share  
2 of Medi-Cal payments to managed care health plans for the  
3 provision of services to dual eligible beneficiaries pursuant to  
4 Section 14182.15.

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

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

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

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

17 (o) Any otherwise applicable provisions of this chapter, Chapter  
18 8 (commencing with Section 14200), or Chapter 8.75 (commencing  
19 with Section 14591) not in conflict with this section or with the  
20 Special Terms and Conditions of the waiver shall apply to this  
21 section.

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

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

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

33 (s) 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 (t) Notwithstanding Chapter 3.5 (commencing with Section  
37 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
38 the department may implement, interpret, or make specific this  
39 section and any applicable federal waivers and state plan  
40 amendments by means of all-county letters, plan letters, plan or

1 provider bulletins, or similar instructions, without taking regulatory  
2 action. Prior to issuing any letter or similar instrument authorized  
3 pursuant to this section, the department shall notify and consult  
4 with stakeholders, including advocates, providers, and  
5 beneficiaries. The department shall notify the appropriate policy  
6 and fiscal committees of the Legislature of its intent to issue  
7 instructions under this section at least five days in advance of the  
8 issuance.

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

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

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

28 14182.17. (a) For the purposes of this section, the definitions  
29 in subdivision (b) of Section 14182.16 shall apply.

30 (b) The department shall ensure and improve the care  
31 coordination and integration of health care services for Medi-Cal  
32 beneficiaries residing in *Coordinated Care Initiative* counties  
33 ~~participating in the demonstration project pursuant to Section~~  
34 ~~14132.275~~ who are either of the following:

35 (1) Dual eligible beneficiaries, as defined in subdivision (b) of  
36 Section 14182.16, who receive Medi-Cal benefits and services  
37 through the demonstration project established pursuant to Section  
38 14132.275 or through mandatory enrollment in managed care  
39 health plans pursuant to Section 14182.16.

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

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

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

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

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

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

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

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

31 (B) Develop and implement an outreach and education program  
32 for beneficiaries to inform them of their enrollment options and  
33 rights, including specific steps to work with consumer and  
34 beneficiary community groups.

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

38 (D) Ensure that managed care health plans and their provider  
39 networks are able to provide communication and services to dual  
40 eligible beneficiaries in alternative formats that are culturally,

1 linguistically, and physically appropriate through means, including,  
2 but not limited to, assistive listening systems, sign language  
3 interpreters, captioning, written communication, plain language,  
4 and written translations.

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

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

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

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

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

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

1 systems, sign language interpreters, captioning, and written  
2 communication.

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

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

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

13 (I) The plan choices.

14 (II) Continuity of care provisions.

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

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

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

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

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

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

38 (B) Assesses the care needs of dual eligible beneficiaries and  
39 coordinates their Medi-Cal benefits across all settings, including

1 coordination of necessary services within, and, when necessary,  
2 outside of the managed care health plan’s provider network.

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

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

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

15 (F) Analyzes Medicare claims data for dual eligible beneficiaries  
16 upon enrollment in a demonstration site pursuant to Section  
17 14132.275 to provide an appropriate transition process for newly  
18 enrolled beneficiaries who are prescribed Medicare Part D drugs  
19 that are not on the demonstration site’s formulary, as required  
20 under the transition of care requirements for Medicare Part D  
21 benefits as described in Chapters 6 and 14 of the Medicare  
22 Managed Care Manual, published by CMS.

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

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

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

31 (A) Except for beneficiaries enrolled in the demonstration  
32 project pursuant to Section 14132.275, forgo interference with a  
33 beneficiary’s choice of primary care physician under Medicare,  
34 and not assign a full-benefit dual eligible beneficiary to a primary  
35 care physician unless it is determined through the risk stratification  
36 and assessment process that assignment is necessary, in order to  
37 properly coordinate the care of the beneficiary or upon the  
38 beneficiary’s request.

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

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

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

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

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

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

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

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

34 (F) Consider behavioral health needs of beneficiaries and  
35 coordinate those services with the county mental health department  
36 as part of the beneficiary's care management plan when  
37 appropriate.

38 (G) Facilitate a beneficiary's ability to access appropriate  
39 community resources and other agencies, including referrals as



1 necessary and appropriate for behavioral services, such as mental  
2 health and substance use disorders treatment services.

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

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

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

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

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

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

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

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

37 (G) Maintain a liaison and provide access to out-of-network  
38 providers, for up to 12 months, for new members enrolled under  
39 Sections 14132.275 and 14182.16 who have an ongoing  
40 relationship with a provider, if the provider will accept the health

1 plan's rate for the service offered, or for nursing facilities and  
2 Community-Based Adult Services, or the applicable Medi-Cal  
3 fee-for-service rate, whichever is higher, and the managed care  
4 health plan determines that the provider meets applicable  
5 professional standards and has no disqualifying quality of care  
6 issues in accordance with guidance from the department, including  
7 all-plan letters. A partial-benefit dual eligible beneficiary enrolled  
8 in Medicare Part A who only receives primary and specialty care  
9 services through a Medi-Cal managed care health plan shall be  
10 able to receive these Medi-Cal services from an out-of-network  
11 Medi-Cal provider for 12 months after enrollment. This  
12 subparagraph shall not apply to out-of-network providers that  
13 furnish ancillary services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (B) Implement performance measures that are required as part  
35 of the contract to provide quality assurance indicators for long-term  
36 services and supports in quality assurance plans required under  
37 the plans' contracts. These indicators shall include factors such as  
38 affirmative member choice, increased independence, avoidance  
39 of institutional care, and positive health outcomes. The department

1 shall develop these quality assurance indicators in consultation  
2 with stakeholder groups.

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

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

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

18 (ii) Any routine financial examinations of managed care health  
19 plans operating in the demonstration project authorized by Section  
20 14132.275 that have been conducted and completed for the  
21 previous calendar year by the Department of Managed Health Care  
22 and the department.

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

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

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

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

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

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

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

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

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

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

29 (D) No later than 90 days prior to the initial plan enrollment  
30 date of the demonstration project pursuant to the provisions of  
31 Sections 14132.275, 14182.16, and of Article 5.7 (commencing  
32 with Section 14186), assess and report to the fiscal and appropriate  
33 policy committees of the Legislature on the readiness of the  
34 managed care health plans to address the unique needs of dual  
35 eligible beneficiaries and Medi-Cal only seniors and persons with  
36 disabilities pursuant to the applicable readiness evaluation criteria  
37 and requirements set forth in paragraphs (1) to (8), inclusive, of  
38 subdivision (b) of Section 14087.48. The report shall also include  
39 an assessment of the readiness of the managed care health plans

1 in each county participating in the demonstration project to have  
2 met the requirements set forth in paragraphs (1) to (9), inclusive.

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

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

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

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

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

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

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

- 1 (V) Design uniform and plain language materials and a process  
2 to inform seniors and persons with disabilities of copays and  
3 covered services so that beneficiaries can make informed choices.
- 4 (VI) Develop a description of the process, except in those  
5 demonstration counties that have a county operated health system,  
6 of automatically assigning beneficiaries into managed care health  
7 plans that shall include a requirement to consider Medicare service  
8 utilization, provider data, and consideration of plan quality.
- 9 (iii) Finalize rates and comprehensive contracts between the  
10 department and participating health plans to facilitate effective  
11 outreach, enroll network providers, and establish benefit packages.  
12 To the extent permitted by CMS, the plan rates and contract  
13 structure shall be provided to the appropriate fiscal and policy  
14 committees of the Legislature and posted on the department's  
15 Internet Web site so that they are readily available to the public.
- 16 (iv) Ensure that contracts have been entered into between plans  
17 and providers including, but not limited to, agreements with county  
18 agencies as necessary.
- 19 (v) Develop network adequacy standards for medical care and  
20 long-term supports and services that reflect the provisions of  
21 paragraph (5).
- 22 (vi) Identify dedicated department or contractor staff with  
23 adequate training and availability during business hours to address  
24 and resolve issues between health plans and beneficiaries, and  
25 establish a requirement that health plans have similar points of  
26 contact and are required to respond to state inquiries when  
27 continuity of care issues arise.
- 28 (vii) Develop a tracking mechanism for inquiries and complaints  
29 for quality assessment purposes, and post publicly on the  
30 department's Internet Web site information on the types of issues  
31 that arise and data on the resolution of complaints.
- 32 (viii) Prepare scripts and training for the department and plan  
33 customer service representatives on all aspects of the program,  
34 including training for enrollment brokers and community-based  
35 organizations on rules of enrollment and counseling of  
36 beneficiaries.
- 37 (ix) Develop continuity of care procedures.
- 38 (x) Adopt quality measures to be used to evaluate the  
39 demonstration projects. Quality measures shall be detailed enough

1 to enable measurement of the impact of automatic plan assignment  
2 on quality of care.

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

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

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

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

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

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

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

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



1     14182.18. (a) *It is the intent of the Legislature that both the*  
2 *managed care plans participating in and providing long-term*  
3 *services and supports under Sections 14182.16 and 14186.2 and*  
4 *the state have protections against either significant overpayment*  
5 *or significant underpayments. Risk corridors are one method of*  
6 *risk sharing that may limit the financial risk of misaligning the*  
7 *payments associated with a contract to furnish long-term services*  
8 *and supports pursuant to a contract under the Coordinated Care*  
9 *Initiative on an at-risk basis.*

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

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

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

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

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

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

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

37    (3) *Risk corridors applied to costs of beneficiary services*  
38 *identified in subparagraph (B) of paragraph (1) shall only be in*  
39 *place for a period of 24 months starting with the first month in*

1 *which mandatory coverage of all Medi-Cal long-term services and*  
2 *supports pursuant to Section 14186.2 has occurred.*

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

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

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

12 *(C) The managed care health plan and the department shall*  
13 *share responsibility for costs in excess of the capitated rate of the*  
14 *plan that are greater than 1 percent above the rate but less than*  
15 *2.5 percent above the rate.*

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

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

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

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

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

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

34 14183.6. (a) The department shall enter into an interagency  
35 agreement with the Department of Managed Health Care to have  
36 the Department of Managed Health Care, on behalf of the  
37 department, conduct financial audits, medical surveys, and a review  
38 of the provider networks of the managed care health plans  
39 participating in the demonstration project and the Medi-Cal  
40 managed care expansion into rural counties, and to provide

1 consumer assistance to beneficiaries affected by the provisions of  
2 Sections 14182.16 and 14182.17. The interagency agreement shall  
3 be updated, as necessary, on an annual basis in order to maintain  
4 functional clarity regarding the roles and responsibilities of these  
5 core activities. The department shall not delegate its authority  
6 under this division as the single state Medicaid agency to the  
7 Department of Managed Health Care.

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

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

13 *14183.6. (a) The department shall enter into an interagency*  
14 *agreement with the Department of Managed Health Care to have*  
15 *the Department of Managed Health Care, on behalf of the*  
16 *department, conduct financial audits, medical surveys, and a*  
17 *review of the provider networks of the managed care health plans*  
18 *participating in the demonstration project and the Medi-Cal*  
19 *managed care expansion into rural counties. The interagency*  
20 *agreement shall be updated, as necessary, on an annual basis in*  
21 *order to maintain functional clarity regarding the roles and*  
22 *responsibilities of these core activities. The department shall not*  
23 *delegate its authority under this division as the single state*  
24 *Medicaid agency to the Department of Managed Health Care.*

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

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

30 *14186. (a) It is the intent of the Legislature that long-term*  
31 *services and supports (LTSS) be covered through managed care*  
32 *health plans in ~~counties participating in the demonstration project~~*  
33 *~~authorized under Section 14132.275~~ Coordinated Care Initiative*  
34 *counties.*

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

37 *(1) Persons receiving health care services through Medi-Cal*  
38 *receive these services through a coordinated health care system*  
39 *that reduces the unnecessary use of emergency and hospital*  
40 *services.*

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

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

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

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

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

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

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

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

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

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

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

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

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

32 ~~It~~

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

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

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

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

12 14186.1. For purposes of this article, the following definitions  
13 shall apply unless otherwise specified:

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

17 ~~(a)~~

18 (b) “Home- and community-based services” means services  
19 provided pursuant to paragraphs (1), (2), and (3) of subdivision  
20 ~~(b)~~ (c).

21 ~~(b)~~

22 (c) “Long-term services and supports” or “LTSS” means all of  
23 the following:

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

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

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

32 (4) Skilled nursing facility services and subacute care services  
33 established under subdivision (c) of Section 14132, including those  
34 services described in Sections 51511 and 51511.5 of Title 22 of  
35 the California Code of Regulations, regardless of whether the  
36 service is included in the basic daily rate or billed separately, and  
37 any leave of absence or bed hold provided consistent with Section  
38 72520 of Title 22 of the California Code of Regulations or the  
39 state plan.

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

4 ~~(e)~~

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

18 ~~(d)~~

19 *(e)* “Managed care health plan” means an individual,  
20 organization, or entity that enters into a contract with the  
21 department pursuant to Article 2.7 (commencing with Section  
22 14087.3), Article 2.8 (commencing with Section 14087.5), Article  
23 2.81 (commencing with Section 14087.96), or Article 2.91  
24 (commencing with Section 14089), of this chapter, or Chapter 8  
25 (commencing with Section 14200). For the purposes of this article,  
26 “managed care health plan” shall not include an individual,  
27 organization, or entity that enters into a contract with the  
28 department to provide services pursuant to Chapter 8.75  
29 (commencing with Section 14591) or the Senior Care Action  
30 Network.

31 ~~(e)~~

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

39 ~~(f)~~

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

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

6 *14186.11. Section 14186.17 shall apply to the provision of*  
7 *CBAS, MSSP, skilled nursing facility, and IHSS services in*  
8 *Coordinated Care Initiative counties as set forth in this article.*

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

11 14186.2. (a) (1) Not sooner than March 1, 2013, all Medi-Cal  
12 long-term services and supports (LTSS) described in subdivision  
13 ~~(b)~~ (c) of Section 14186.1 shall be services that are covered under  
14 managed care health plan contracts and shall be available only  
15 through managed care health plans to beneficiaries residing in  
16 ~~counties participating in the demonstration project authorized under~~  
17 ~~Section 14132.275~~ *Coordinated Care Initiative counties*, except  
18 for the exemptions provided for in subdivision (c). The director  
19 shall consult with the Legislature, CMS, and stakeholders when  
20 determining the implementation date for this section. The  
21 department shall pay managed care health plans using a capitation  
22 ratesetting methodology that pays for all Medi-Cal benefits and  
23 services, including all LTSS, covered under the managed care  
24 health plan contract. In order to receive any LTSS through  
25 Medi-Cal, Medi-Cal beneficiaries shall mandatorily enroll in a  
26 managed care health plan for the provision of Medi-Cal benefits.

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

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

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



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

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

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

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

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

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

23 (i) Except in counties with county organized health systems  
24 operating pursuant to Article 2.8 (commencing with Section  
25 14087.5), have other health coverage.

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

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

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

35 (B) Persons enrolled in the Program of All-Inclusive Care for  
36 the Elderly (PACE) pursuant to Chapter 8.75 (commencing with  
37 Section 14591), or a managed care organization licensed under  
38 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter  
39 2.2 (commencing with Section 1340) of Division 2 of the Health  
40 and Safety Code) that has previously contracted with the

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

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

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

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

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

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

17 14186.3. (a) (1) No sooner than July 1, 2012,  
18 Community-Based Adult Services (CBAS) shall be a Medi-Cal  
19 benefit covered under every managed care health plan contract  
20 and available only through managed care health plans. Medi-Cal  
21 beneficiaries who are eligible for CBAS shall enroll in a managed  
22 care health plan in order to receive those services, except for  
23 beneficiaries exempt under subdivision (c) of Section 14186.2 or  
24 in counties or geographic regions where Medi-Cal benefits are not  
25 covered through managed care health plans. Notwithstanding  
26 subdivision (a) of Section 14186.2 and pursuant to the provisions  
27 of an approved federal waiver or plan amendment, the provision  
28 of CBAS as a Medi-Cal benefit through a managed care health  
29 plan shall not be limited to *Coordinated Care Initiative* counties  
30 ~~participating in the demonstration project authorized under Section~~  
31 ~~14132.275.~~

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

1 (b) (1) Beginning in the 2012 calendar year, managed care  
2 health plans shall collaborate with MSSP providers to begin  
3 development of an integrated, person-centered care management  
4 and care coordination model and explore how the MSSP program  
5 model may be adapted to managed care while maintaining the  
6 efficacy of the MSSP model. The California Department of Aging  
7 and the department shall work with the MSSP site association and  
8 managed care health plans to develop a template contract to be  
9 used by managed care health plans contracting with MSSP sites  
10 in counties where the demonstration project pursuant to Section  
11 ~~14132.275 is implemented~~ *Coordinated Care Initiative counties*.

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

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

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

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

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

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

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

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

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

25 (4) (A) Effective January 1, 2015, or 19 months after the  
26 commencement of beneficiary enrollment ~~in the demonstration~~  
27 ~~project authorized pursuant to Section 14132.275 into managed~~  
28 ~~care pursuant to Sections 14182 and 14182.16~~, or on the date that  
29 any necessary federal approvals or waivers are obtained, whichever  
30 is later, MSSP services in ~~counties where the demonstration project~~  
31 ~~authorized under Section 14132.275 is implemented~~ *Coordinated*  
32 *Care Initiative counties* shall transition from a federal waiver  
33 pursuant to Section 1915(c) under the federal Social Security Act  
34 (42 U.S.C. Sec. 1396n et seq.) to a benefit administered and  
35 allocated by managed care health plans.

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

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

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

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

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

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

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

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

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

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

13 14186.36. (a) It is the intent of the Legislature that a universal  
14 assessment process for LTSS be developed and tested. The initial  
15 uses of this tool may inform future decisions about whether to  
16 amend existing law regarding the assessment processes that  
17 currently apply to LTSS programs, including IHSS.

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

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

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

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

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

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

20 (ii) The criteria for reassessment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (g) Until existing law relating to the IHSS assessment process  
38 pursuant to Article 7 (commencing with Section 12300) of Chapter  
39 3 is amended, beneficiaries shall have the option to request an  
40 additional assessment using the previous assessment process for



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

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

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

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

18 14186.4. (a) This article shall be implemented only to the  
19 extent that all necessary federal approvals and waivers have been  
20 obtained and only if and to the extent that federal financial  
21 participation is available.

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

34 (e)

35 (b) To implement this article, the department may contract with  
36 public or private entities. Contracts, or amendments to current  
37 contracts, entered into under this article may be on a  
38 noncompetitive bid basis and shall be exempt from all of the  
39 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 (4) Review or approval of feasibility study reports and the  
9 requirements of Sections 4819.35 to 4819.37, inclusive, and  
10 Sections 4920 to 4928, inclusive, of the State Administrative  
11 Manual.

12 ~~(d)~~

13 (c) Notwithstanding Chapter 3.5 (commencing with Section  
14 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
15 the State Department of Health Care Services and State Department  
16 of Social Services may implement, interpret, or make specific this  
17 section by means of all-county letters, plan letters, plan or provider  
18 bulletins, or similar instructions, without taking regulatory action.  
19 Prior to issuing any letter or similar instrument authorized pursuant  
20 to this section, the departments shall notify and consult with  
21 stakeholders, including beneficiaries, providers, and advocates.

22 ~~(e)~~

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

28 ~~(f)~~

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

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

3 ~~(g)~~

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

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

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

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

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

36 14301.1. (a) For rates established on or after August 1, 2007,  
37 the department shall pay capitation rates to health plans  
38 participating in the Medi-Cal managed care program using actuarial  
39 methods and may establish health-plan- and county-specific rates.  
40 Notwithstanding any other law, this section shall apply to any

1 managed care organization, licensed under the Knox-Keene Health  
2 Care Service Plan Act of 1975 (Chapter 2.2 (commencing with  
3 Section 1340) of Division 2 of the Health and Safety Code), that  
4 has contracted with the department as a primary care case  
5 management plan pursuant to Article 2.9 (commencing with  
6 Section 14088) of Chapter 7 to provide services to beneficiaries  
7 who are HIV positive or who have been diagnosed with AIDS for  
8 rates established on or after July 1, 2012. The department shall  
9 utilize a county- and model-specific rate methodology to develop  
10 Medi-Cal managed care capitation rates for contracts entered into  
11 between the department and any entity pursuant to Article 2.7  
12 (commencing with Section 14087.3), Article 2.8 (commencing  
13 with Section 14087.5), and Article 2.91 (commencing with Section  
14 14089) of Chapter 7 that includes, but is not limited to, all of the  
15 following:

- 16 (1) Health-plan-specific encounter and claims data.
- 17 (2) Supplemental utilization and cost data submitted by the  
18 health plans.
- 19 (3) Fee-for-service data for the underlying county of operation  
20 or other appropriate counties as deemed necessary by the  
21 department.
- 22 (4) Department of Managed Health Care financial statement  
23 data specific to Medi-Cal operations.
- 24 (5) Other demographic factors, such as age, gender, or  
25 diagnostic-based risk adjustments, as the department deems  
26 appropriate.
- 27 (b) To the extent that the department is unable to obtain  
28 sufficient actual plan data, it may substitute plan model, similar  
29 plan, or county-specific fee-for-service data.
- 30 (c) The department shall develop rates that include  
31 administrative costs, and may apply different administrative costs  
32 with respect to separate aid code groups.
- 33 (d) The department shall develop rates that shall include, but  
34 are not limited to, assumptions for underwriting, return on  
35 investment, risk, contingencies, changes in policy, and a detailed  
36 review of health plan financial statements to validate and reconcile  
37 costs for use in developing rates.
- 38 (e) The department may develop rates that pay plans based on  
39 performance incentives, including quality indicators, access to  
40 care, and data submission.

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

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

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

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

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

29 (j) Notwithstanding Chapter 3.5 (commencing with Section  
30 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
31 the department may set and implement managed care capitation  
32 rates, and interpret or make specific this section and any applicable  
33 federal waivers and state plan amendments by means of plan letters,  
34 plan or provider bulletins, or similar instructions, without taking  
35 regulatory action.

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

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

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

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

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

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

20 *14301.1. (a) For rates established on or after August 1, 2007,*  
21 *the department shall pay capitation rates to health plans*  
22 *participating in the Medi-Cal managed care program using*  
23 *actuarial methods and may establish health-plan- and*  
24 *county-specific rates. The department shall utilize a county- and*  
25 *model-specific rate methodology to develop Medi-Cal managed*  
26 *care capitation rates for contracts entered into between the*  
27 *department and any entity pursuant to Article 2.7 (commencing*  
28 *with Section 14087.3), Article 2.8 (commencing with Section*  
29 *14087.5), and Article 2.91 (commencing with Section 14089) of*  
30 *Chapter 7 that includes, but is not limited to, all of the following:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 ~~SEC. 10. (a) In the event the department has not received, by~~  
26 ~~February 1, 2013, federal approval, or notification indicating~~  
27 ~~pending approval, of a mutual ratesetting process, shared federal~~  
28 ~~savings, and a six-month enrollment period in the demonstration~~  
29 ~~project pursuant to paragraph (2) of subdivision (l) of Section~~  
30 ~~14132.275, effective March 1, 2013, Sections 14132.275, 14182.16,~~  
31 ~~and 14182.17, and Article 5.7 (commencing with Section 14186)~~  
32 ~~of Chapter 7 shall become inoperative. The director shall execute~~  
33 ~~a declaration of these facts and post it on the department's Internet~~  
34 ~~Web site.~~

35 (b) For purposes of this section, “shared federal savings” means  
36 a methodology that meets the conditions of paragraphs (1) and (2),  
37 or paragraph (3).

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



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

6 ~~(3) An alternate methodology that, in the determination of the~~  
7 ~~Director of Finance, in consultation with the Director of Health~~  
8 ~~Care Services and the Joint Legislative Budget Committee, will~~  
9 ~~result in the same level of ongoing savings, as estimated in the~~  
10 ~~Budget Act of 2012 for the 2012–13, 2013–14, 2014–15, and~~  
11 ~~2015–16 fiscal years.~~

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

14 ~~SEC. 15. (a) In the event the department has not received, by~~  
15 ~~February 1, 2013, federal approval, or notification indicating~~  
16 ~~pending approval, of a mutual ratesetting process, shared federal~~  
17 ~~savings, and a six-month enrollment period in the demonstration~~  
18 ~~project pursuant to Section 14132.275 of the Welfare and~~  
19 ~~Institutions Code, effective March 1, 2013, this act shall become~~  
20 ~~inoperative, the amendments made to the sections amended by this~~  
21 ~~act shall be inoperative, and the sections added by this act shall be~~  
22 ~~inoperative. The director shall execute a declaration attesting to~~  
23 ~~these facts and post it on the department's Internet Web site.~~

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

27 ~~(1) The state and the federal Centers for Medicare and Medicaid~~  
28 ~~Services share in the combined savings for Medicare and Medi-Cal,~~  
29 ~~as estimated in the Budget Act of 2012 for the 2012–13, 2013–14,~~  
30 ~~2014–15, and 2015–16 fiscal years.~~

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

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

1 ~~Budget Act of 2012 for the 2012–13, 2013–14, 2014–15, and~~  
2 ~~2015–16 fiscal years.~~

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

5 ~~SEC. 16. In the event that the conditions set forth in Section~~  
6 ~~10 of Assembly Bill 1468 or Senate Bill 1008 of the 2011–12~~  
7 ~~Regular Session of the Legislature are not met as described and~~  
8 ~~the provisions of law set forth in Section 10 of those bills become~~  
9 ~~inoperative, Sections 6531.5 and Title 23 (commencing with~~  
10 ~~Section 110000) of the Government Code and Sections 12300.5,~~  
11 ~~12300.6, 12300.7, and 12302.6 of the Welfare and Institutions~~  
12 ~~Code as added by this act shall become inoperative as of March~~  
13 ~~1, 2013.~~

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

17 ~~Sec. 17. In the event the director decides to entirely forego the~~  
18 ~~provision of services as specified in Section 14186.4 of the Welfare~~  
19 ~~and Institutions Code, Section 6531.5 and Title 23 (commencing~~  
20 ~~with Section 110000) of the Government Code and Sections~~  
21 ~~12300.5, 12300.6, and 12300.7 of the Welfare and Institutions~~  
22 ~~Code as added by this act shall cease to be implemented except as~~  
23 ~~follows:~~

24 ~~(a) For an agreement that has been negotiated and approved by~~  
25 ~~the Statewide Authority, the Statewide Authority shall continue~~  
26 ~~to retain its authority pursuant to Section 6531.5 and Title 23~~  
27 ~~(commencing with Section 110000) of the Government Code and~~  
28 ~~Sections 12300.5, 12300.6, 12300.7, and 12302.6 of the Welfare~~  
29 ~~and Institutions Code as added by this act, and remain the employer~~  
30 ~~of record for all individual providers covered by the agreement~~  
31 ~~until the agreement expires or is subject to renegotiation, whereby~~  
32 ~~the authority of the Statewide Authority shall terminate and the~~  
33 ~~county shall be the employer of record in accordance with Section~~  
34 ~~12302.25 of the Welfare and Institutions Code and may establish~~  
35 ~~an employer of record pursuant to Section 12301.6 of the Welfare~~  
36 ~~and Institutions Code.~~

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

1 ~~record for purposes of bargaining and in accordance with Section~~  
2 ~~12302.25 of the Welfare and Institutions Code, and may establish~~  
3 ~~an employer of record pursuant to Section 12301.6 of the Welfare~~  
4 ~~and Institutions Code.~~

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

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

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

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

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

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

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

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

6 (B) Sections 14132.276, 14132.277, 14182.16, 14182.17,  
7 14182.18, and 14301.2 of the Welfare and Institutions Code.

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

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

12 (E) Section 6531.5 of the Government Code.

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

15 (G) Sections 12300.5, 12300.6, 12300.7, 12302.6, 12306.15,  
16 12330, 14186.35, and 14186.36 of the Welfare and Institutions  
17 Code.

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

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

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

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

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

1 12302.25 of the Welfare and Institutions Code and may establish  
2 an employer of record pursuant to Section 12301.6 of the Welfare  
3 and Institutions Code.

4 (C) For an agreement that has been assumed by the Statewide  
5 Authority that was negotiated and approved by a predecessor  
6 agency, the Statewide Authority shall cease being the employer of  
7 record and the county shall be reestablished as the employer of  
8 record for purposes of bargaining and in accordance with Section  
9 12302.25 of the Welfare and Institutions Code, and may establish  
10 an employer of record pursuant to Section 12301.6 of the Welfare  
11 and Institutions Code.

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

15 SEC. 35. For the purpose of the Coordinated Care Initiative,  
16 the amount of five hundred thousand dollars (\$500,000) is hereby  
17 appropriated from the General Fund to the State Department of  
18 Health Care Services for purposes of notifying dual eligible  
19 beneficiaries and providers regarding the provisions of this Act,  
20 and shall be available for encumbrance and expenditure until June  
21 30, 2014.

22 SEC. 36. This act is a bill providing for appropriations related  
23 to the Budget Bill within the meaning of subdivision (e) of Section  
24 12 of Article IV of the California Constitution, has been identified  
25 as related to the budget in the Budget Bill, and shall take effect  
26 immediately.

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