SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM
3.43
(ID # 3067)

MEETING DATE:
Tuesday, December 6, 2016

FROM: EXECUTIVE OFFICE:

SUBJECT: EXECUTIVE OFFICE: Report from the Legislative Platform Ad Hoc Committee, regarding a letter to the Governor requesting the continued support of the Coordinated Care Initiative in the 2017-2018 State Budget [$0]

RECOMMENDED MOTION: That the Board of Supervisors:
Receive and Concur with the Board Legislative Ad Hoc Committee and its action to support the Coordinated Care Initiative.
ACTION: Policy

Brian Nestande 12/1/2016

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ N/A	$ N/A	$ N/A	$ N/A
NET COUNTY COST	$ N/A	$ N/A	$ N/A	$ N/A
SOURCE OF FUNDS: N/A			Budget Adjustment: N/A	
			For Fiscal Year: N/A	

C.E.O. RECOMMENDATION:

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Ashley, seconded by Supervisor Washington and duly carried, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Tavaglione, Washington and Ashley
Nays:	None
Absent:	Benoit
Date:	December 6, 2016
xc:	EO

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

3.43

BACKGROUND:

Summary

On January 5, 2016 the Board adopted the 2016 state and federal legislative platform. During discussion on the item, Supervisor Benoit pointed out the problem of legislative changes that occur without sufficient time for the item to be brought to the full board for discussion. Thereby an Ad Hoc committee comprised of the Board Chair and Vice Chair was appointed. The Ad Hoc committee would act on legislation, per the request of the Executive Office, in the form of a letter in support or opposition signed by the Chair and Vice Chair. The Executive Office is directed to bring the item to the next Board meeting for consent.

On November 21, 2016 the Ad Hoc committee sent a letter to Governor Edmund G. Brown, Jr. requesting the continued support of the Coordinated Care Initiative in the 2017-2018 State Budget.

The Coordinated Care Initiative was enacted through SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012) (attached).

Passage of the Coordinated Care Initiative (CCI) marked an important step toward transforming California's Medi-Cal (Medicaid) care delivery system to better serve the state's low-income seniors and persons with disabilities. Building upon many years of stakeholder discussions, the CCI began the process of integrating the delivery of medical, behavioral, and long-term care services while also providing a road map to integrate Medicare and Medi-Cal for people in both programs, which are thus called "dual eligible" beneficiaries.

The Inland Empire, which includes the counties of Riverside and San Bernardino, is one of the first geographic regions to launch the CCI on April 1, 2014. The program, in the Inland Empire, has more than 27,200 active enrollments; IEHP Dual Choice maintains approximately 22,000 members, the highest plan enrollment in the state. Combined, Riverside and San Bernardino counties have the second highest Cal MediConnect enrollment percentage in the state.

Studies overwhelmingly show that the Coordinated Care Initiative is delivering on the promise of **simplifying** and **enhancing** health care to beneficiaries dually eligible for Medicare and Medi-Cal. Furthermore, similar studies on the overall satisfaction with CCI emphasize that:

- Californians enrolled in Cal MediConnect report high satisfaction with their care.
- Over 83 percent of Cal MediConnect beneficiaries rate their overall quality of care as good or excellent
- Beneficiaries maintain high satisfaction with care coordination, lower out-of-pocket costs, more streamlined services, minimized language barriers, effective problem-solving, and access to specialized resources.

Impact on Residents and Businesses

The action presented would affect residents of Riverside County by ensuring that the Governor knows the positive impacts that CCI is having on the constituents of Riverside County.

SB-1036 Public social services: in-home supportive services. (2011-2012)

Senate Bill No. 1036

CHAPTER 45

An act to amend Section 6253.2 of, to add Section 6531.5 to, to add Title 23 (commencing with Section 110000) to, and to add and repeal Section 110035.5 of, the Government Code, and to amend Sections 10101.1, 12306, and 12306.1 of, and to add Sections 12300.5, 12300.6, 12300.7, 12302.6, 12306.15, 12330, 14186.35, and 14186.36 to, the Welfare and Institutions Code, relating to public social services, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 27, 2012. Filed with Secretary of State June 27, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1036, Committee on Budget and Fiscal Review. Public social services: in-home supportive services.

Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization. Existing law authorizes services to be provided under the IHSS program either through the employment of individual providers, a contract between the county and an entity for the provision of services, the creation by the county of a public authority, or a contract between the county and a nonprofit consortium.

This bill would establish the California In-Home Supportive Services Authority (Statewide Authority) and would deem the authority a joint powers authority and a public entity separate and apart from the parties that have appointing power to the authority, as specified, or the employers of those individuals so appointed. This bill would require the authority to be the entity authorized to meet and confer in good faith regarding wages, benefits, and other terms and conditions of employment with representatives of recognized employee organizations for any individual provider who is employed by a recipient of supportive services.

Under existing law, any public authority created under the IHSS program is deemed to be the employer of in-home support services personnel within the meaning of the Meyers-Milias Brown Act, which governs local employer-employee relations. Existing law also provides that any nonprofit consortium contracting with a county is deemed the employer of in-home supportive services personnel for the purposes of collective bargaining over wages, hours, and other terms and conditions of employment. Existing law also establishes the Public Employment Relations Board (PERB) in state government as a means of resolving disputes and enforcing the statutory duties and rights of employers and employees under, among other provisions, the Educational Employment Relations Act, the Higher Education Employer-Employee Relations Act, the Ralph C. Dills Act, and the Meyers-Milias-Brown Act.

This bill would establish the In-Home Supportive Services Employer-Employee Relations Act for the purpose of resolving disputes regarding wages, benefits, and other terms and conditions of employment between the California In-Home Supportive Services Authority (Statewide Authority), as specified, and recognized employee organizations. Under the act, the Statewide Authority would be deemed to be the employer of record, for purposes of collective bargaining, of individual providers of in-home supportive services in each county, upon

implementation by a county, in accordance with certain procedures. Pursuant to the act, employees would have the right to form, join, and participate in the activities of employee organizations for the purpose of representation on all matters within the scope of representation.

The bill would require separate bargaining units to be created, consistent with bargaining units that have been recognized by predecessor agencies, as defined. The bill would require the Statewide Authority to meet and confer in good faith with employee organizations on all matters within the scope of representation, as specified. The bill would further require the Statewide Authority to assume the predecessor agency's rights and obligations under any memorandum of understanding or agreement between the predecessor agency and the recognized employee organization that is in effect on the county implementation date until it expires. The bill would provide that individual providers employed by a predecessor agency would retain employee status and would not be required by the Statewide Authority to requalify to receive payment for providing services.

The bill also would make the powers and duties of PERB applicable to its provisions, establish legal procedures for appeals regarding recognition or certification of an employee organization, authorize agency shop agreements and fee obligations, establish mediation and impasse procedures, and authorize the Statewide Authority to adopt reasonable rules and regulations relating to determining the status of organizations and associations. The bill also would authorize PERB and the Statewide Authority to adopt emergency regulations to implement the act, as specified.

The bill would establish the In-Home Supportive Services Fund within the State Treasury. Moneys in the fund would be made available, upon appropriation by the Legislature, to the Statewide Authority for the purposes of funding its functions.

This bill would require all counties, commencing July 1, 2012, to have a County IHSS Maintenance of Effort (MOE), and would require counties to pay the County IHSS MOE instead of paying the nonfederal share of IHSS costs, as specified.

The bill would require the Statewide Authority to assume prescribed responsibilities in a county or city and county upon notification by the Director of Health Care Services that the assignment of eligible Medi-Cal beneficiaries described in a specified provision of law has been completed in that county or city and county. The bill would require the county or city and county to take certain actions upon this notification. By increasing the duties of local officials, this bill would create a state-mandated local program.

This bill would authorize managed care health plans, as defined, to assume the authority, previously granted to counties, to contract for the provision of in-home supportive services with a qualified agency, as defined, subject to specified restrictions and requirements.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. One of the methods by which these services are provided is pursuant to contracts with various types of managed care plans.

This bill would provide that, not sooner than March 1, 2013, IHSS shall be a Medi-Cal benefit available through managed care health plans in specified counties. This bill would require that the managed care health plans, among other things, enter into a memoranda of understanding and contract with applicable entities, as specified, and would provide that IHSS recipients receiving services through managed care health plans shall retain specified rights and responsibilities. This bill would, until July 1, 2017, require the State Department of Health Care Services, the State Department of Social Services, and the California Department of Aging to establish a stakeholder workgroup, as prescribed, to develop a universal assessment process, including a universal assessment tool, to be used for home- and community-based services, as defined, including IHSS.

This bill would become inoperative under certain circumstances.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

This bill would appropriate $1,000 from the General Fund to the State Department of Health Care Services for administration.

This bill would become operative only if AB 1468 or SB 1008 of the 2011–12 Regular Session is enacted and takes effect.

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

Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 6253.2 of the Government Code is amended to read:

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

(b) Copies of names, addresses, and telephone numbers of persons described in subdivision (a) shall be made available, upon request, to an exclusive bargaining agent and to any labor organization seeking representation rights pursuant to Section 12301.6 or 12302 of the Welfare and Institutions Code or the In-Home Supportive Services Employer-Employee Relations Act (Title 23 (commencing with Section 110000)). This information shall not be used by the receiving entity for any purpose other than the employee organizing, representation, and assistance activities of the labor organization.

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

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

SEC. 2. Section 6531.5 is added to the Government Code, to read:

6531.5. (a) There is hereby created the California In-Home Supportive Services Authority, hereafter referred to as the Statewide Authority. Notwithstanding any other law, the Statewide Authority shall be deemed a joint powers authority created pursuant to this article and is a public entity separate and apart from the parties that have appointing power to the Statewide Authority or the employers of those individuals so appointed. Notwithstanding the requirements of this article, an agreement shall not be required to create the Statewide Authority.

(b) The Statewide Authority shall consist of the following five members:

(1) Two members shall be county officials who are appointed by, and who serve at the pleasure of, the Governor.

(2) Three members shall be the Director of Social Services, the Director of Health Care Services, and the Director of Finance in their ex officio capacities, or their duly appointed representatives.

(c) The members of the Statewide Authority shall serve without compensation.

(d) The Statewide Authority shall not be subject to Sections 6501, 6505, and 53051.

(e) The Statewide Authority shall appoint an advisory committee that shall be comprised of not more than 13 individuals. No less than 50 percent of the membership of the advisory committee shall be individuals who are current or past users of personal assistance services paid for through public or private funds or recipients of services in-home supportive.

(1) At least two members of the advisory committee shall be a current or former provider of in-home supportive services.

(2) Individuals who represent organizations that advocate for people with disabilities or seniors may be appointed to the advisory committee.

(3) Individuals from each representative organization that are designated representatives of IHSS providers shall be appointed to the advisory committee.

(4) The Statewide Authority shall designate a department employee to provide ongoing advice and support to the advisory committee.

(f) Prior to the appointment of members to a committee authorized by subdivision (e), the Statewide Authority shall solicit recommendations for qualified members through a fair and open process that includes the provision of reasonable written notice to, and reasonable response time by, members of the general public and interested persons and organizations.

(g) The advisory committee established pursuant to subdivision (e) shall provide ongoing advice and recommendations regarding in-home supportive services to the Statewide Authority, the State Department of Social Services, and the State Department of Health Care Services.

SEC. 3. Title 23 (commencing with Section 110000) is added to the Government Code, to read:

TITLE 23. In-Home Supportive Services Employer-Employee Relations Act
CHAPTER 1. General Provisions

110000. This title shall be known and may be cited as the In-Home Supportive Services Employer-Employee Relations Act.

110001. It is the purpose of this title to promote full communication between the California In-Home Supportive Services Authority (the Statewide Authority) and the recognized employee organization representing independent providers by providing a reasonable method of resolving disputes regarding wages, benefits, and other terms and conditions of employment, as defined in Section 110023, between the Statewide Authority for in-home supportive services and recognized employee organizations. It is also the purpose of this title to promote the improvement of personnel management and employer-employee relations within the Statewide Authority by providing a uniform basis for recognizing the right of independent providers to join organizations of their own choice and be represented by those organizations for purposes of collective bargaining with the Statewide Authority. This title is intended to strengthen methods of administering employer-employee relations through the establishment of uniform and orderly methods of communication between the recognized employee organizations and the Statewide Authority. Except as expressly provided herein, this title is not intended to require changes in existing bargaining units or memoranda of agreement or understanding.

110002. Except as otherwise provided by the Legislature, employees shall have the right to form, join, and participate in the activities of employee organizations of their own choosing for the purpose of representation on all matters within the scope of representation. Employees also shall have the right to refuse to join or participate in the activities of employee organizations.

110003. As used in this title:

(a) "Board" means the Public Employment Relations Board established pursuant to Section 3541.

(b) "Employee" or "individual provider" means any person authorized to provide in-home supportive services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code, and Sections 14132.95, 14132.952, and 14132.956 of the Welfare and Institutions Code, pursuant to the individual provider mode, as referenced in Section 12302.2 of the Welfare and Institutions Code. As used in this title, "employee" or "individual provider" does not include any person providing in-home supportive services pursuant to the county-employed homemaker mode or the contractor mode, as authorized in Section 12302 of the Welfare and Institutions Code. Individual providers shall not be deemed to be employees of the Statewide Authority for any other purpose, except as expressly set forth in this title.

(c) "Employee organization" means an organization that includes employees, as defined in subdivision (b), and that has as one of its primary purposes representing those employees in their relations with the Statewide

Authority.

(d) "Employer" means, for the purposes of collective bargaining, the Statewide Authority established pursuant to Section 6531.5. The in-home supportive services recipient shall be the employer of an individual in-home supportive services provider with the unconditional and exclusive right to hire, fire, and supervise his or her provider.

(e) "In-home supportive services" means services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code, and Sections 14132.95, 14132.952, and 14132.956 of the Welfare and Institutions Code.

(f) "In-home supportive services recipient" means the individual who receives the in-home supportive services provided by the individual provider. The in-home supportive services recipient is the employer for the purposes of hiring, firing, and supervising his or her respective individual provider.

(g) "Mediation" means effort by an impartial third party to assist in reconciling a dispute regarding wages, benefits, and other terms and conditions of employment, as defined in Section 110023, between representatives of the employer and the recognized employee organization or recognized employee organizations through interpretation, suggestion, and advice.

(h) "Meet and confer in good faith" means that the employer, or those representatives as it may designate, and representatives of recognized employee organizations, shall have the mutual obligation personally to meet and confer promptly upon request by either party and continue for a reasonable period of time in order to exchange freely information, opinions, and proposals, and to endeavor to reach agreement on matters within the scope of representation prior to the adoption of the annual Budget Act.

(i) "Predecessor agency" means a county, a local public authority, or a nonprofit consortium established pursuant to Section 12301.6 of the Welfare and Institutions Code before the effective date of this title.

(j) "Recognized employee organization" means an employee organization that has been formally acknowledged as follows:

(1) Before the effective date of this title, by a county, a local public authority, or a nonprofit consortium established pursuant to Section 12301.6 of the Welfare and Institutions Code, as the representative of its employees.

(2) On or after the effective date of this title, by the Statewide Authority.

(k) "Statewide Authority" means the California In-Home Supportive Services Authority established pursuant to Section 6531.5.

CHAPTER 2. Transitional Provisions

110004. It is the intent of the Legislature to stabilize the labor and employment relations of individual providers in order to provide continuity of care and services to the maximum extent possible, and consistent with the responsibilities of the Statewide Authority under the act adding this title.

110005. For the purposes of this title, the county implementation date is defined in subdivision (a) of Section 12300.7 of the Welfare and Institutions Code.

110006. For purposes of collective bargaining, and as expressly set forth in subdivision (d) of Section 110003, the Statewide Authority is deemed to be the employer of record of individual providers in each county as of the county implementation date. In-home supportive services recipients shall retain the right to hire, fire, and supervise the work of the individual providers providing services to them.

110007. Individual providers employed by any predecessor agency as of the county implementation date shall retain employee status and shall not be required by the Statewide Authority to requalify to receive payment for providing services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code. In the same manner as set forth in subdivision (e) of Section 12305.86 of the Welfare and Institutions Code, the Statewide Authority shall accept a clearance that was obtained or accepted by any predecessor agency pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code. Existence of a clearance shall be determined by

verification through the case management, information, and payroll system of the predecessor agency that the predecessor agency has deemed the provider to be eligible to receive payment for providing services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code.

110008. On the county implementation date, separate bargaining units shall be created consistent with the bargaining units that have been recognized by predecessor agencies. Bargaining units consisting of employees in a single county shall be the only appropriate unit for collective bargaining under this title. In those counties where no recognized employee organization exists as of the county implementation date, a bargaining unit consisting of all employees in that county shall be deemed an appropriate unit for collective bargaining.

110009. If, on the county implementation date, individual providers are represented by a recognized employee organization, the Statewide Authority shall be deemed the successor employer of the predecessor agency for the purposes of negotiating a collective bargaining agreement, and shall be obligated to recognize and to meet and confer in good faith with the recognized employee organization on all matters within the scope of representation, as defined in Section 110023, as to those individual providers.

110010. Negotiations between the Statewide Authority and recognized employee organizations shall be conducted only in the following manner:

(a) As of July 1, 2012, all recognized employee organizations affiliated with the same national parent union shall negotiate as a coalition on behalf of all bargaining units they represent. If recognized employee organizations are affiliated with two or more different national parent unions, those recognized employee organizations shall also negotiate as a coalition on behalf of all bargaining units they represent.

(b) An employee organization obtaining recognition after July 1, 2012, which is affiliated with the same national parent union or unions as the coalitions described in subdivision (a), shall become a part of the coalition affiliated with its same national parent union or unions.

(c) An employee organization not affiliated with a national parent union covered by subdivision (a), that obtains recognition after July 1, 2012, and represents fewer than 100,000 employees subject to this title, shall negotiate as a member of a coalition, separate from the coalitions described in subdivision (a) and comprised of all those recognized employee organizations on behalf of all units they collectively represent. If that employee organization represents 100,000 or more employees subject to this title, it shall have the right to negotiate as its own coalition on behalf of all bargaining units it represents.

(d) Each coalition negotiating with the Statewide Authority may enter into supplemental bargaining of unit-specific issues for inclusion in, or as an addendum to, collective bargaining agreements, subject to the parties' agreement regarding the issues and procedures for supplemental bargaining. This section does not prohibit coordination of bargaining between two or more bargaining coalitions.

110011. (a) Except as otherwise expressly provided in this title, the enactment of this title shall not be a cause for the employer or any predecessor agency to modify or eliminate any existing memorandum of agreement or understanding, or to modify existing wages, benefits, or other terms and conditions of employment. Except to the extent set forth in this title, the enactment of this title shall not prevent the modification of existing wages, benefits, or terms and conditions of employment through the meet and confer in good faith process or, in those situations in which the employees are not represented by a recognized employee organization, through appropriate procedures.

(b) On the county implementation date, subject to Section 12306.15 of the Welfare and Institutions Code, the Statewide Authority shall assume the predecessor agency's rights and obligations under any memorandum of understanding or agreement between the predecessor agency and a recognized employee organization that is in effect on the county implementation date for the duration thereof. Absent mutual consent to reopen, the terms of any transferred memorandum of understanding or agreement shall continue until the memorandum of understanding or agreement has expired. If a memorandum of understanding or agreement between a recognized employee organization and a predecessor agency has expired and has not been replaced by a successor memorandum of understanding or agreement as of the county implementation date, the Statewide Authority shall assume the obligation to meet and confer in good faith with the recognized employee organization.

(c) Notwithstanding any other provision of law, except to the extent set forth in this chapter and as limited by Section 110023, the terms and conditions of any memorandum of understanding or agreement between a predecessor agency and a recognized employee organization in effect on the county implementation date shall not be reduced, except by mutual agreement between the recognized employee organization and the Statewide Authority.

(d) Nothing in this title shall be construed to relieve any predecessor agency of its obligation to meet and confer in good faith with a recognized employee organization pursuant to the Meyers-Milias-Brown Act (Chapter 10 (commencing with Section 3500) of Division 4 of Title 1) until the county implementation date. Nothing in this title shall require the predecessor agency to meet and confer after the Statewide Authority assumes the predecessor agency's rights and obligations on the county implementation date.

(e) With the exception of all economic terms covered by Section 12306.15 of the Welfare and Institutions Code and notwithstanding any other provision of law, beginning July 1 , 2012, and ending on the county implementation date as set forth in subdivision (a) of Section 12300.7 of the Welfare and Institutions Code, any alterations or modifications to either current or expired memoranda of understanding that were in effect on July 1, 2012, and any newly negotiated memoranda of understanding or agreements reached after July 1, 2012, shall be submitted for review to the State Department of Social Services. This review requirement shall be performed by the department until the Statewide Authority becomes operational, after which date the Statewide Authority shall continue to perform this review requirement. If, upon review, but not later than 180 days after the county commences transition pursuant to paragraph (1) of subdivision (g) of Section 14132.275 of the Welfare and Institutions Code, the department or Statewide Authority reasonably determines that there are one or more newly negotiated or amended noneconomic terms in the memorandum of understanding or agreement to which it objects for a bona fide business-related reason, the department or Statewide Authority shall provide written notice to the signatory recognized employee organization of each objection and the reason for it. Upon demand from the recognized employee organization, the department, or the Statewide Authority, the parties shall meet and confer regarding the objection and endeavor to reach agreement prior to the county implementation date. If an agreement is not reached by the county implementation date, the objectionable language is deemed inoperable. All terms to which no objection is made shall be deemed accepted by the Statewide Authority. If the Statewide Authority fails to provide the 180 days' notice of objection, it shall be deemed waived.

110012. If the Statewide Authority and the recognized employee organization negotiate changes to locally administered health benefits for individual providers, the Statewide Authority shall give 90 days' notice to the county of the agreed-upon changes.

CHAPTER 3. Administration

110013. The Legislature hereby finds and declares that collective bargaining for individual providers under this title constitutes a matter of statewide concern. Therefore, this title is applicable to all counties, notwithstanding charter provisions to the contrary as set forth in Section 110005.

110014. Where the language of this title is the same or substantially the same as that contained in Chapter 10 (commencing with Section 3500) of Division 4 of Title 1, it shall be interpreted and applied by the board in a manner consistent with and in accordance with judicial interpretations of the same language.

110015. Except as provided in this title, the powers and duties of the board described in Sections 3541.3 and 3541.5 shall also apply, as appropriate, to this title. Included among the appropriate powers of the board are the powers to order elections, to conduct any election the board orders, to order unit modifications consistent with Section 110008, and to adopt rules.

110016. Notwithstanding any other law, if a decision by an administrative law judge regarding the recognition, certification, decertification, or unit modification, consistent with Section 110008, of an employee organization is appealed, the decision shall be deemed the final order of the board if the board does not issue a ruling that supersedes the decision no later than 180 days after the appeal is filed.

110017. (a) Any charging party, respondent, or intervener aggrieved by a final decision or order of the board in an unfair practice case, except a decision of the board not to issue a complaint in such a case, and any party to a final decision or order of the board in a unit determination consistent with Section 110008, or in a

representation, recognition, or election matter that is not brought as an unfair practice case, may petition for a writ of extraordinary relief from that decision or order. A board order directing an election shall not be stayed pending judicial review.

(b) A petition for a writ of extraordinary relief shall be filed in the district court of appeal having jurisdiction over the county where the events giving rise to the decision or order occurred. The petition shall be filed within 30 days from the date of the issuance of the board's final decision or order, or order denying reconsideration, as applicable. Upon the filing of the petition, the court shall cause notice to be served upon the board and thereafter shall have jurisdiction of the proceeding. The board shall file in the court the record of the proceeding, certified by the board, within 10 days after the clerk's notice unless that time is extended by the court for good cause shown. The court shall have jurisdiction to grant any temporary relief or restraining order it deems just and proper, and in like manner to make and enter a decree enforcing, modifying, and enforcing as modified, or setting aside in whole or in part the decision or order of the board. The findings of the board with respect to questions of fact, including ultimate facts, if supported by substantial evidence on the record considered as a whole, shall be conclusive. Title 1 (commencing with Section 1067) of Part 3 of the Code of Civil Procedure relating to writs shall, except where specifically superseded by this section, apply to proceedings pursuant to this section.

(c) If the time to petition for extraordinary relief from a board decision or order has expired, the board may seek enforcement of any final decision or order in a district court of appeal or superior court having jurisdiction over the county where the events giving rise to the decision or order occurred. The board shall respond within 10 days to any inquiry from a party to the action as to why the board has not sought court enforcement of the final decision or order. If the response does not indicate that there has been compliance with the board's final decision or order, the board shall seek enforcement of the final decision or order upon the request of the party. The board shall file in the court the record of the proceeding, certified by the board, and appropriate evidence disclosing the failure to comply with the decision or order. If, after hearing, the court determines that the order was issued pursuant to the procedures established by the board and that the person or entity refuses to comply with the order, the court shall enforce the order by writ of mandamus or other proper process. The court may not review the merits of the order.

CHAPTER 4. Labor Relations

110018. No individual provider shall be subject to punitive action or denied promotion, or threatened with any such treatment, for the exercise of lawful action as an elected, appointed, or recognized representative of any employee bargaining unit.

110019. (a) Notwithstanding Section 110002, any other provision of this title, or any other law, rule, or regulation, an agency shop agreement may be negotiated between the employer and a recognized public employee organization that has been recognized as the exclusive or majority bargaining agent, in accordance with this title. As used in this title, "agency shop" means an arrangement that requires an employee, as a condition of continued employment, either to join the recognized employee organization or to pay the organization a service fee in an amount not to exceed the standard initiation fee, periodic dues, and general assessments of the organization, to be determined by the organization in accordance with applicable law.

(b) In addition to the procedure prescribed in subdivision (a), an agency shop arrangement between the Statewide Authority and a recognized employee organization that has been recognized as the exclusive or majority bargaining agent shall be placed in effect, without a negotiated agreement, upon (1) a signed petition of 30 percent of the employees in the applicable bargaining unit requesting an agency shop agreement and an election to implement an agency fee arrangement, and (2) the approval of a majority of employees who cast ballots and vote in a secret ballot election in favor of the agency shop agreement. The petition may be filed only after the recognized employee organization has requested the employer to negotiate on an agency shop arrangement and, beginning seven working days after the employer received this request, the two parties have had 30 calendar days to attempt good faith negotiations in an effort to reach agreement. An election that shall not be held more frequently than once a year shall be conducted by the State Mediation and Conciliation Service with the Department of Industrial Relations in the event that the employer and the recognized employee organization cannot agree within 10 days from the filing of the petition to select jointly a neutral person or entity to conduct the election. In the event of an agency fee arrangement outside of an agreement that is in effect, the recognized employee organization shall indemnify and hold the employer harmless against any liability arising from a claim, demand, or other action relating to the employer's compliance with the agency fee obligation.

(c) An individual provider who is a member of a bona fide religion, body, or sect that has historically held conscientious objections to joining or financially supporting public employee organizations shall not be required to join or financially support a public employee organization as a condition of employment. The employee may be required, in lieu of periodic dues, initiation fees, or agency shop fees, to pay sums equal to the dues, initiation fees, or agency shop fees to a nonreligious, nonlabor charitable fund exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, chosen by the employee from a list of at least three of these funds, designated in a memorandum of understanding between the employer and the recognized employee organization, or if the memorandum of understanding fails to designate the funds, then to a fund of that type chosen by the employee. Proof of the payments shall be made on a monthly basis to the employer as a condition of continued exemption from the requirement of financial support to the public employee organization.

(d) An agency shop provision in a memorandum of understanding that is in effect may be rescinded by a majority vote of all the employees in the unit covered by the memorandum of understanding, provided that: (1) a request for that type of vote is supported by a petition containing the signatures of at least 30 percent of the employees in the unit, (2) the vote is by secret ballot, and (3) the vote may be taken at any time during the term of the memorandum of understanding, but in no event shall there be more than one vote taken during that term.

(e) A recognized employee organization that has agreed to an agency shop provision or is a party to an agency shop arrangement shall keep an adequate itemized record of its financial transactions and shall make available annually, to the employer with which the agency shop provision was negotiated, and to the employees who are members of the organization, within 60 days after the end of its fiscal year, a detailed written financial report thereof in the form of a balance sheet and an operating statement, certified as to accuracy by its president and treasurer or corresponding principal officer, or by a certified public accountant. An employee organization required to file financial reports under the federal Labor-Management Reporting and Disclosure Act of 1959 (29 U.S.C. Sec. 401 et seq.) covering employees governed by this title, or required to file financial reports under Section 3546.5, may satisfy the financial reporting requirement of this section by providing the employer with a copy of the financial reports.

110020. (a) Nothing in this title shall affect the right of an employee to authorize a dues or service fees deduction from his or her salary or wages pursuant to Article 6 (commencing with Section 1150) of Chapter 1 of Division 4 of Title 1.

(b) Either the Controller or the State Department of Social Services shall deduct the payment of dues or service fees to a recognized employee organization as required by an agency shop arrangement between the recognized employee organization and the Statewide Authority.

(c) Agency fee obligations, including, but not limited to, dues or agency fee deductions on behalf of a recognized employee organization, shall continue in effect as long as the employee organization is the recognized bargaining representative, notwithstanding the expiration of any agreement between the employer and the recognized employee organization.

110021. If a predecessor agency is party to any memorandum of understanding or agreement with any bargaining unit that includes individual providers that contains an agency shop provision as of the effective date of this title, the predecessor agency and the employer shall be obligated to honor the terms of the agency shop provision, including indemnification provisions, if any, for the duration of the memorandum of understanding or agreement, and until the adoption of a successor memorandum of understanding or agreement. However, upon the request of a recognized employee organization, an agency shop provision in effect on the county implementation date may be reopened for the sole purpose of renegotiating the terms of that provision in accordance with this title. The implementation of this title shall not be a cause for a new agency shop election.

110022. Recognized employee organizations shall have the right to represent their members in their employment relations with the employer. Employee organizations may establish reasonable restrictions regarding who may join and may make reasonable provisions for the dismissal of individuals from membership. Nothing in this section shall prohibit an employee from appearing on his or her own behalf in his or her employment relations with the employer.

110023. The scope of representation shall include all matters relating to wages, benefits, and other terms and conditions of employment. The scope of representation shall exclude the following:

(a) Functions performed by, or on behalf of, a county, which shall include all of the following:

(1) Determining an applicant's eligibility for IHSS benefits.

(2) Assessing, approving, and authorizing an IHSS recipient's initial and continuing need for services.

(3) Enrolling providers and conducting provider orientation.

(4) Conducting criminal background checks on all potential providers.

(5) Providing assistance to IHSS recipients in finding eligible providers through the establishment of a provider registry, as well as providing orientation to recipients.

(6) Pursuing overpayment recovery recollection.

(7) Performing quality assurance activities.

(8) Performing any other function or responsibility required pursuant to statute or regulation to be performed by the county.

(b) The right to hire, fire, and supervise the individual provider, which is reserved to the in-home supportive services recipient.

110024. (a) Except in cases of emergency as provided in this section, the Statewide Authority shall give reasonable written notice to each recognized employee organization affected by any rule, practice, or policy directly relating to matters within the scope of representation proposed to be adopted by the employer and shall give each recognized employee organization the opportunity to meet with the employer.

(b) In cases of emergency when the Statewide Authority determines that any rule, policy, or procedure must be adopted immediately without prior notice or meeting with a recognized employee organization, the employer shall provide notice and an opportunity to meet at the earliest practicable time following the adoption of the rule, policy, or procedure.

110025. (a) Consistent with Section 12300.5 of the Welfare and Institutions Code, the Statewide Authority shall meet and confer in good faith regarding matters within the scope of representation with representatives of recognized employee organizations and shall consider fully those presentations as are made by the employee organization on behalf of its members prior to arriving at a determination of policy or course of action.

(b) The process should include adequate time for the resolution of impasses pursuant to any impasse resolution procedure set forth in this title.

110026. The Statewide Authority and employee organizations shall not interfere with, intimidate, restrain, coerce, or discriminate against employees because of the exercise of their rights under Section 110002.

110027. (a) The Statewide Authority shall grant exclusive recognition to employee organizations designated or selected pursuant to rules established by the board for employees of the Statewide Authority or an appropriate unit thereof, subject to the right of an employee to represent himself or herself. The board shall establish reasonable procedures for petitions and holding elections and determining appropriate units consistent with Section 110008. In a representation election, a majority of the votes cast by the employees in the appropriate bargaining unit shall be required.

(b) A bargaining unit in existence as of the effective date of this title shall remain in existence unless changed pursuant to subdivision (a).

110028. If an agreement is reached by the representatives of the Statewide Authority and a recognized employee organization or recognized employee organizations, they shall jointly prepare a written memorandum of the understanding, which shall not be binding, and present it to the Legislature for determination by majority vote.

110029. (a) If, after a reasonable period of time, representatives of the employer and the recognized employee organization fail to reach agreement, the dispute shall be referred to mediation before a mediator mutually agreeable to the parties. If the parties are unable to agree upon the mediator, either party may request the board to appoint a mediator in accordance with rules adopted by the board.

(b) The costs of mediation shall be divided one-half to the employer and one-half to the recognized employee organization or recognized employee organizations.

110030. (a) If the parties are unable to effect settlement of the controversy within 30 days after the appointment of a mediator, the parties shall submit their differences to a factfinding panel. Within five days after receipt of the written request, each party shall select a person to serve as its member of the factfinding panel. The board shall, within five days after the selection of panel members by the parties, select a chairperson of the factfinding panel.

(b) Within five days after the board selects a chairperson of the factfinding panel, the parties may mutually agree upon a person to serve as chairperson in lieu of the person selected by the board.

(c) The panel shall, within 10 days after its appointment, meet with the parties or their representatives, either jointly or separately, and may make inquiries and investigations, hold hearings, and take any other steps it deems appropriate. For the purpose of the hearings, investigations, and inquiries, the panel shall have the power to issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence. Any state agency, as defined in Section 11000, or any political subdivision of the state, shall furnish the panel, upon its request, with all records, papers, and information in their possession relating to any matter under investigation by or in issue before the panel.

(d) In arriving at their findings and recommendations, the factfinders shall consider, weigh, and be guided by all the following criteria:

(1) State and federal laws that are applicable to the employer.

(2) Local rules, regulations, or ordinances.

(3) Stipulations of the parties.

(4) The interests and welfare of the public and the financial ability of the employer.

(5) Comparison of the wages, benefits, and terms and conditions of employment of the employees involved in the factfinding proceeding with the wages, benefits, and terms and conditions of employment of other employees performing similar services in comparable counties.

(6) The consumer price index for goods and services, commonly known as the cost of living.

(7) The overall compensation presently received by the employees, including direct wage compensation, vacations, holidays, and other excused time, insurance and pensions, medical and hospitalization benefits, the continuity and stability of employment, and all other benefits received.

(8) Any other facts, not confined to those specified in paragraphs (1) to (7), inclusive, which are normally or traditionally taken into consideration in making the findings and recommendations.

110031. (a) If the dispute is not settled within 30 days after the appointment of the factfinding panel, or, upon agreement by both parties within a longer period, the panel shall make findings of fact and recommend terms of settlement, which shall be advisory only. The factfinders shall submit, in writing, any findings of fact and recommended terms of settlement to the parties before they are made available to the public. The employer shall make these findings and recommendations publicly available within 10 days after their receipt.

(b) The costs for the services of the panel chairperson, whether selected by the board or agreed upon by the parties, shall be equally divided between the parties, and shall include per diem fees, if any, and actual and necessary travel and subsistence expenses. The per diem fees shall not exceed the per diem fees stated on the chairperson's résumé on file with the board. The chairperson's bill showing the amount payable by the parties shall accompany his or her final report to the parties and the board. The chairperson may submit interim bills to the parties in the course of the proceedings, and copies of the interim bills shall also be sent to the board. The parties shall make payment directly to the chairperson.

(c) Any other mutually incurred costs shall be borne equally by the public agency and the employee organization. Any separately incurred costs for the panel member selected by each party shall be borne by that party.

(d) Nothing in this chapter shall be construed to prohibit the mediator appointed pursuant to Section 110029, upon mutual agreement of the parties, from continuing mediation efforts on the basis of the findings of fact and recommended terms of settlement made pursuant to Section 110031.

110032. After the applicable mediation procedure has been exhausted, factfinding has been completed and made public, and no resolution has been reached by the parties, the Statewide Authority may declare an impasse and implement its last, best, and final offer. The unilateral implementation of the Statewide Authority's last, best, and final offer shall not deprive a recognized employee organization of the right each year to meet and confer on matters within the scope of representation, whether or not those matters are included in the unilateral implementation, prior to the adoption of the annual budget or as otherwise required by law.

110033. The Statewide Authority shall allow a reasonable number of representatives of recognized employee organizations reasonable time off without loss of compensation or other benefits when formally meeting and conferring with representatives of the employer on matters within the scope of representation.

110034. The Statewide Authority shall not do any of the following:

(a) Impose or threaten to impose reprisals on employees, to discriminate or threaten to discriminate against employees, or otherwise to interfere with, restrain, or coerce employees because of their exercise of rights guaranteed by this title.

(b) Deny to employee organizations the rights guaranteed to them by this title.

(c) Refuse or fail to meet and negotiate in good faith with a recognized employee organization. For purposes of this subdivision, knowingly providing a recognized employee organization with inaccurate information regarding the financial resources of the employer, whether or not in response to a request for information, constitutes a refusal or failure to meet and negotiate in good faith.

(d) Dominate or interfere with the formation or administration of any employee organization, contribute financial or other support to any employee organization, or in any way encourage employees to join any organization in preference to another.

(e) Refuse to participate in good faith in any applicable impasse procedure.

110035. (a) The Statewide Authority may adopt reasonable rules and regulations for all of the following:

(1) Registering employee organizations.

(2) Determining the status of organizations and associations as employee organizations or bona fide associations.

(3) Identifying the officers and representatives who officially represent employee organizations and bona fide associations.

(4) Any other matters that are necessary to carry out the purposes of this title.

(b) The board shall establish procedures whereby recognition of employee organizations formally recognized as majority representatives pursuant to a vote of the employees may be revoked by a majority vote of the employees only after a period of not less than 12 months following the date of recognition.

(c) The employer shall not unreasonably withhold recognition of employee organizations.

(d) Employees and employee organizations may challenge a rule or regulation of the employer as a violation of this title. This subdivision shall not be construed to restrict or expand the board's jurisdiction or authority as set forth in subdivisions (a) to (c), inclusive, of Section 3541.3.

110035.5. (a) The board and the Statewide Authority may adopt emergency regulations to implement this title. The initial adoption, amendment, or repeal of the regulations authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6, and the board and the Statewide Authority are

hereby exempted for that purpose from the requirements of subdivision (b) of Section 11346.1. After the initial adoption, amendment, or repeal of an emergency regulation pursuant to this section, the board and the Statewide Authority shall not request approval from the Office of Administrative Law to readopt the regulation as an emergency regulation pursuant to Section 11346.1.

(b) The adoption, amendment, or repeal of a regulation authorized by this section is hereby exempted from subdivision (d) of Section 11346.1 and Section 11349.6, and the board or Statewide Authority shall transmit the regulations directly to the Secretary of State for filing. The regulations shall become effective immediately upon filing with the Secretary of State.

(c) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

110036. The provisions of this title are severable. If any provision of this title or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. Section 10101.1 of the Welfare and Institutions Code is amended to read:

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

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

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

SEC. 5. Section 12300.5 is added to the Welfare and Institutions Code, to read:

12300.5. (a) The California In-Home Supportive Services Authority, hereafter referred to as the Statewide Authority, established pursuant to Section 6531.5 of the Government Code, shall be the entity authorized to meet and confer in good faith regarding wages, benefits, and other terms and conditions of employment in accordance with Title 23 (commencing with Section 110000) of the Government Code, with representatives of recognized employee organizations for any individual provider who is employed by a recipient of in-home supportive services described in Section 12300.

(b) The Statewide Authority and the Department of Human Resources and other state departments may enter into a memorandum of understanding or other agreement to have the Department of Human Resources meet and confer on behalf of the Statewide Authority for the purposes described in subdivision (a) or to provide the Statewide Authority with other services, including, but not limited to, administrative and legal services.

(c) Neither the state nor the Statewide Authority shall be deemed to be the employer of any individual provider who is employed by a recipient of in-home supportive services as described in Section 12300 for purposes of liability due to the negligence or intentional torts of the individual provider.

SEC. 6. Section 12300.6 is added to the Welfare and Institutions Code, to read:

12300.6. There is hereby created the In-Home Supportive Services Fund in the State Treasury. Moneys in the fund shall be made available, upon appropriation by the Legislature, to the California In-Home Supportive Services Authority, for the purposes of funding the functions of the Statewide Authority.

SEC. 7. Section 12300.7 is added to the Welfare and Institutions Code, to read:

12300.7. (a) No sooner than March 1, 2013, the California In-Home Supportive Services Authority shall assume the responsibilities set forth in Title 23 (commencing with Section 110000) of the Government Code 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 Sections 14132.275, 14182.16, and 14182.17 have been completed in that county or city and county.

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

(1) Continue to have its public authority perform the functions set forth in the county ordinance existing at the time of the notification pursuant to subdivision (a) and established pursuant to Section 12301.6, excluding subdivision (c) of that section.

(2) Continue to have the entity perform the functions in the existing contract at the time of the notification pursuant to subdivision (a) established pursuant to Section 12301.6, excluding subdivision (c) of that section.

(3) Assume the functions performed by an entity or public authority pursuant to Section 12301.6, excluding subdivision (c) and paragraph (2) of subdivision (i) of that section.

(c) If a county or city and county assumes the functions described in paragraph (3) of subdivision (b), it may do any of the following:

(1) Contract for the performance of any or all of the functions assumed.

(2) Contract with an entity pursuant to Section 12301.6 for the performance of any or all functions assumed.

(3) Establish a public authority pursuant to Section 12301.6 for the performance of any functions assumed.

SEC. 8. Section 12302.6 is added to the Welfare and Institutions Code, to read:

12302.6. (a) A managed care health plan may enter into contracts pursuant to paragraph (14) of subdivision (a) of Section 14186.35 solely in the manner prescribed in this section.

(b) For purposes of this section:

(1) "Agency" means a city, county, city and county agency, local health district, nonprofit entity, or a proprietary agency that has or seeks a contract to provide in-home supportive services pursuant to Section 12302 or this article.

(2) "Contract provider" means any person employed by an agency for the provision of services listed in this subdivision.

(3) "County" means a political unit, unless otherwise indicated.

(4) "Department" means the State Department of Social Services.

(5) "Individual provider" means any person authorized to provide in-home supportive services under this article and Sections 14132.95, 14132.952, and 14132.956, pursuant to the individual provider mode referenced in Section 12302.2. As used in this paragraph, "individual provider" shall not include any person providing in-home supportive services pursuant to a county-employed homemaker mode or any person employed by an agency.

(6) "Individual provider rate" means the combined total rate for wages and benefits for individual providers, as approved by the Statewide Authority or its delegate.

(7) "Managed care health plan" shall have the same meaning as set forth in Section 14186.1.

(8) "Qualified agency" means an agency that has been certified by the department.

(9) "Responsible party" means an officer or director of the applicant, a shareholder with a beneficial interest in the applicant exceeding 10 percent, or the person who will be primarily responsible for any contract with the managed care health plan.

(10) "Statewide Authority" means the California In-Home Supportive Services Authority established pursuant to Section 6531.5 of the Government Code.

(c) Managed care health plans shall assume the authority granted to counties pursuant to Section 12302 to contract for the provision of in-home supportive services with an agency.

(1) (A) Managed care health plans shall assume the authority as described in subdivision (a) only upon their integration into Medi-Cal managed care pursuant to Article 5.7 (commencing with Section 14186) of Chapter 7.

(B) If, at the time a managed care health plan assumes contracting authority pursuant to this subdivision with respect to a particular geographic area, there is an existing contract between the county and an agency for the provision of in-home supportive services, the managed care health plan shall enter into a contract with the county to continue providing the services, and the county shall maintain its existing contract with the agency for the provision of in-home supportive services until such time as that contract is due to expire. Counties that have these existing contracts with agencies at the time a managed care health plan assumes contracting authority pursuant to this subdivision shall automatically be certified as qualified agencies.

(2) An agency that is a county, or has an existing contract with a county, as of the date that the managed care health plan in the corresponding geographic area assumes contracting authority with respect to agencies, shall be deemed to be certified as a qualified agency with respect to the geographic area in which the agency has a contract to provide in-home supportive services with respect to the type of in-home supportive services provided pursuant to that contract. Where a county has an existing contract with an agency, the certification provided for in this subdivision shall remain in effect until the triennial deadline established by paragraph (3) of subdivision (d) that occurs no less than one year after the expiration of the contract in effect at the time that the managed care health plan assumes contracting authority with respect to agencies. However, if an agency that is party to such a contract seeks to expand the geographic area in which it is certified to provide services or seeks to expand the types of services for which it is certified, it must submit an application in accordance with Section 12342.3.

(d) An agency contracting with a managed care health plan for the provision of in-home supportive services shall be certified as a qualified agency by the department in consultation with the State Department of Health Care Services.

(1) The certification of an agency as a qualified agency shall be with respect to a specific geographic area and an identified category of services.

(2) An agency seeking certification as a qualified agency shall submit to the department a verified application showing that it satisfies the conditions and providing the information specified. The department shall develop the form and establish the conditions to be met. The verified application shall include the three most recent audited financial statements or other independently verified documentation showing that the applicant maintains liquid assets sufficient to cover 180 days of in-home supportive services' operating expenses, evidence of liability and workers' compensation insurance, and evidence that the applicant has not been the subject of bankruptcy proceedings in the last five years.

(3) The department shall establish an annual deadline for submitting applications for certification pursuant to this subdivision. The department shall also establish a triennial deadline for submitting renewals of certification pursuant to this subdivision. The department shall process and approve or deny applications within 120 days of receipt of a completed application.

(4) In determining whether an agency may be certified as a qualified agency, the department, in consultation with the State Department of Health Care Services, shall consider documents and evidence to ensure that, among other things identified by the department, the agency:

(A) Guarantees the continuity and reliability of services to recipients.

(B) Guarantees the supervision of contract providers.

(C) Guarantees that each contract provider has been screened in accordance with Sections 12305.81 and 12305.87.

(D) Guarantees that each contract provider is capable of and is providing the service authorized.

(E) Complies with applicable rules and regulations regarding civil rights and those rights' relations with contract providers.

(F) Is capable of providing high-quality and reliable in-home supportive services.

(G) Is capable of complying with this section, any rules or regulations promulgated under this section, and any applicable federal rules and regulations.

(H) Has not demonstrated a pattern and practice of violations of state or federal laws and regulations based on any available information.

(5) An application for certification under this subdivision may be denied by the department if the department determines that the applying agency or a responsible party has violated a law or regulation that is substantially related to the qualifications or duties of the applying agency or is substantially related to the functions of the business for which certification was, or is to be, issued, or on the ground that an applying agency knowingly made a false statement of fact required to be revealed in an application for certification.

(6) The department shall develop a written appeal process for any agency dissatisfied with the decision of the department regarding certification.

(e) (1) A qualified agency shall submit verified cost reports to the department documenting that the qualified agency is in compliance with subdivision (i). The cost reports shall be verified by the responsible party and by a representative of a certified public accounting firm.

(2) The verified cost reports required by paragraph (1) shall be submitted within 90 calendar days after the end of each year and within 60 calendar days after any change in compensation negotiated by the Statewide Authority for individual providers has gone into effect.

(f) A managed care health plan that has entered into a contract in the manner prescribed in this section shall notify the department within 30 days if the contract between the managed care health plan and the qualified agency is suspended or terminated for any reason.

(g) Except as provided in subdivision (h), a recipient of in-home supportive services may only be referred to a qualified agency by the county, managed care health plan, or care coordination teams. Qualified agencies shall establish procedures to ensure contract limitations on caseload are being met and there is coordination of information between managed care health plans, qualified agencies, counties, and the department. When a recipient has been referred to the managed care health plan, the qualified agency may provide services in the following circumstances:

(1) It has been determined that the recipient is unable to function as the employer of the provider due to dementia, cognitive impairment, or other similar issues.

(2) The recipient has been identified to need services under this mode by the care coordination team created pursuant to paragraph (3) of subdivision (b) of Section 14186.

(3) The recipient is unable to retain a provider due to geographic isolation and distance, authorized hours, or other reasons.

(h) When a recipient who is severely impaired, as described in Section 12303.4, is referred to a qualified agency by a managed care health plan, the county, or the care coordination team, the qualified agency may provide emergency backup services, as needed, when a provider is unavailable due to vacation, illness, or other extraordinary circumstances, or the recipient is in the process of hiring or replacing a provider. Qualified agencies shall establish procedures to ensure contract limitations on caseload are being met and there is coordination of information between managed care health plans, qualified agencies, counties, and the department. Service hours provided under the emergency backup criteria shall be deducted from the in-home supportive services recipient's current authorized hours of services and on an hour-to-hour basis coordinated with the county and the department to ensure hours are accurately captured and not duplicated per in-home supportive services program requirements.

(i) Wages and benefits for contract providers for their provision of in-home supportive services shall not be less than the individual provider rate negotiated by the Statewide Authority for the county where services are provided.

(j) Any contract entered into between a managed care health plan and a qualified agency shall provide for a minimum amount of service utilization and shall be approved by the department. In no case, however, shall in-home supportive services recipients referred for services exceed 5 percent of the caseload in the county where services are provided.

(k) The department shall establish reasonable fees to be paid by agencies and qualified agencies for administering the provisions of this section, including, but not limited to, fees associated with processing applications for certification and renewals of certification, and fees associated with monitoring and enforcing compliance, including any fees reflecting the costs associated with investigating complaints, to the extent permissible by law. These fees shall be sufficient to cover the department's reasonable costs incurred in administering the provisions of this section.

(l) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement, interpret, or make specific this section by means of all-county letters, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including beneficiaries, providers, and advocates.

SEC. 9. Section 12306 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

SEC. 10. Section 12306.1 of the Welfare and Institutions Code is amended to read:

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

(1) Each county has provided the department with documentation of the approval of the county board of supervisors of the proposed public authority or nonprofit consortium rate, including wages and related

expenditures. The documentation shall be received by the department before the department and the State Department of Health Care Services may approve the increase.

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

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

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

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

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

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

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

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

(6) Notwithstanding paragraphs (2) to (5), inclusive, the state shall participate as provided in subdivision (c) in a total cost of wages up to nine dollars and fifty cents ($9.50) per hour and in individual health benefits up to sixty cents ($0.60) per hour. This paragraph shall become operative on July 1, 2009.

(7) (A) The Legislature finds and declares that injunctions issued by the courts have prevented the state from implementing the changes described in paragraph (6) during the pendency of litigation. To avoid confusion for

providers, recipients, and other stakeholders, it is therefore the intent of the Legislature to temporarily suspend the reductions described in that paragraph until July 1, 2012, to allow the litigation to reach a final result.

(B) Paragraph (6) shall not be implemented until July 1, 2012, and as of that date shall only be implemented if a court of competent jurisdiction has issued an order, that is not subject to appeal or for which the time to appeal has expired, upholding its validity.

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

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

(f) Any increase in overall state participation in wage and benefit increases under paragraphs (2) to (5), inclusive, of subdivision (d), shall be limited to a wage and benefit increase of one dollar ($1) per hour with respect to any fiscal year. With respect to actual changes in specific wages and health benefits negotiated through the collective bargaining process, the state shall participate in the costs, as approved in subdivision (c), up to the maximum levels as provided under paragraphs (2) to (6), inclusive, of subdivision (d).

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

SEC. 11. Section 12306.15 is added to the Welfare and Institutions Code, to read:

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

(b) (1) The County IHSS MOE base year shall be the 2011–12 state fiscal year. The County IHSS MOE base shall be defined as the amount actually expended by each county on IHSS services and administration in the County IHSS MOE base year, as reported by each county to the Department of Social Services, except that for administration, the County IHSS MOE base shall include no more or no less than the full match for the county's allocation from the state.

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

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

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

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

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

(3) (A) Notwithstanding paragraphs (1) and (2), in fiscal years when the combined total of 1991 realignment revenues received pursuant to Sections 11001.5, 6051.2, and 6201.2 of the Revenue and Taxation Code, for the prior fiscal year is less than the combined total received for the next prior fiscal year, the inflation factor shall be zero.

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

(d) In addition to the adjustment in subdivision (c), the County IHSS MOE shall be adjusted for the annualized cost of locally negotiated, mediated, or imposed increases in provider wages or health benefits.

(1) (A) If the State Department of Social Services approves the rates and other economic terms for a locally negotiated, mediated, or imposed increase in the provider wages, health benefits, or other economic terms pursuant to Section 12306.1 and paragraph (3), the state shall pay 65 percent, and each county shall pay 35 percent, of the nonfederal share of the cost increase.

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

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

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

(3) In addition to the rate approval requirements in Section 12306.1, it shall be presumed by the State Department of Social Services that negotiated rates and other economic terms within the following limits are approved:

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

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

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

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

SEC. 12. Section 12330 is added to the Welfare and Institutions Code, to read:

12330. (a) No later than January 1, 2014, the State Department of Social Services, in consultation with the department, and in collaboration with stakeholders including, but not limited to, IHSS recipients and recognized employee representatives, shall develop a training curriculum for IHSS providers that shall address issues of consistency, accountability, and increased quality of care for IHSS recipients.

(b) Participation in the training developed pursuant to subdivision (a) shall be voluntary.

(c) Nothing in this section shall require that training be funded by the state.

(d) This section shall not be construed to preclude a managed care health plan, as part of the care coordination team, from developing recipient-specific voluntary training curriculum for an IHSS provider who has been integrated into a beneficiary's care coordination team.

(e) The IHSS recipient shall continue to have the right to train his or her individual provider.

SEC. 13. Section 14186.35 is added to the Welfare and Institutions Code, to read:

14186.35. (a) Not sooner than March 1, 2013, in-home supportive services (IHSS) shall be a Medi-Cal benefit available through managed care health plans in a county where this article is effective. Managed care health

plans shall cover IHSS in accordance with the standards and requirements set forth in Article 7 (commencing with Section 12300) of Chapter 3. Specifically, managed care health plans shall do all of the following:

(1) Ensure access to, provision of, and payment for IHSS for individuals who meet the eligibility criteria for IHSS.

(2) Retain recipients' right to be the employer, to select, engage, direct, supervise, schedule, and terminate IHSS providers in accordance with Section 12301.6.

(3) Assume all financial liability for payment of IHSS services for recipients receiving said services pursuant to managed care.

(4) Create a care coordination team, as needed and subject to the consumer's consent, that shall include county IHSS social workers, consumers and their representatives, managed care health plans, and may include IHSS providers and others as applicable, for individual care plan development. For individuals identified to participate in care coordination, managed care health plans shall include the consumer or his or her authorized representative, or both, health plan, county IHSS staff if the consumer is an IHSS recipient, Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP) case managers if the consumer is a CBAS or MSSP client, and may include others as identified by the consumer.

(5) Maintain the paramedical role and function of providers as authorized pursuant to Sections 12300 and 12301.

(6) Ensure compliance with all requirements set forth in Section 14132.956 and any resulting state plan amendments.

(7) Adhere to quality assurance provisions and individual data and other standards and requirements as specified by the State Department of Social Services including state and federal quality assurance requirements.

(8) Share confidential beneficiary data with the contractors specified in this section to improve care coordination, promote shared understanding of the consumer's needs, and ensure appropriate access to IHSS and other long-term services and supports.

(9) (A) Enter into a memorandum of understanding with a county agency and the county's public authority or nonprofit consortium pursuant to Section 12301.6 to continue to perform their respective functions and responsibilities pursuant to the existing ordinance or contract until the Director of Health Care Services provides notification pursuant to subdivision (a) of Section 12300.7 for that county.

(B) Following the notification pursuant to subdivision (a) of Section 12300.7, enter into a memorandum of understanding with the county agencies to perform the following activities:

(i) Assess, approve, and authorize each recipient's initial and continuing need for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3. County agency assessments shall be shared with the care coordination teams established under paragraph (4), when applicable, and the county agency thereafter may receive and consider additional input from the care coordination team.

(ii) Plans may contract with counties for additional assessments for purposes of paragraph (6) of subdivision (b) of Section 14186.

(iii) Enroll providers, conduct provider orientation, and retain enrollment documentation pursuant to Sections 12301.24 and 12305.81.

(iv) Conduct criminal background checks on all potential providers and exclude providers consistent with the provisions set forth in Sections 12305.81, 12305.86, and 12305.87.

(v) Provide assistance to IHSS recipients in finding eligible providers through the establishment of a provider registry as well as provide training for providers and recipients as set forth in Section 12301.6.

(vi) Refer all providers to the California In-Home Supportive Services Authority or nonprofit consortium for the purposes of wages and benefits.

(vii) Pursue overpayment recovery pursuant to Section 12305.83.

(viii) Perform quality assurance activities including routine case reviews, home visits, and detecting and reporting suspected fraud pursuant to Section 12305.71.

(ix) Share confidential data necessary to implement the provisions of this section.

(x) Appoint an advisory committee of not more than 11 people, and no less than 50 percent of the membership of the advisory committee shall be individuals who are current or past users of personal assistance paid for through public or private funds or recipients of IHSS services.

(xi) Continue to perform other functions necessary for the administration of the IHSS program pursuant to Article 7 (commencing with Section 12300) of Chapter 3 and regulations promulgated by the State Department of Social Services pursuant to that article.

A county may contract with a nonprofit consortium, or may establish a public authority pursuant to Section 12301.6 for the performance of any or all of the activities set forth in a contract with a managed care health plan pursuant to this section.

(10) Enter into a contract with the State Department of Social Services to perform the following activities:

(A) Pay wages to IHSS providers in accordance with the wages negotiated pursuant to Title 23 (commencing with Section 110000) of the Government Code.

(B) Perform obligations on behalf of the IHSS recipient as the employer of his or her provider, including unemployment compensation, disability benefits, applicable federal and state taxes, and federal old age survivor's and disability insurance through the state's payroll system for IHSS in accordance with Sections 12302.2 and 12317.

(C) Provide technical assistance and support for all payroll-related activities involving the state's payroll system for IHSS, including, but not limited to, the monthly restaurant allowance as set forth in Section 12303.7, the monthly cash payment in advance as set forth in Section 12304, and the direct deposit program as set forth in Section 12304.4.

(D) Share recipient and provider data with managed care health plans for members who are receiving IHSS to support care coordination.

(E) Provide an option for managed care health plans to participate in quality monitoring activities conducted by the State Department of Social Services pursuant to subdivision (f) of Section 12305.7 for recipients who are plan members.

(11) In concert with the department, timely reimburse the State Department of Social Services for payroll and other obligations of the beneficiary as the employer, including unemployment compensation, disability benefits, applicable federal and state taxes, and federal old age survivors and disability insurance benefits through the state's payroll system.

(12) In a county where services are provided in the homemaker mode, enter into a contract with the county to implement the provision of services pursuant to the homemaker mode as set forth in Section 12302.

(13) Retain the IHSS individual provider mode as a choice available to beneficiaries in all participating managed care health plans in each county.

(14) In a county where services are provided pursuant to a contract, enter into a contract with a city, county, or city and county agency, a local health district, a voluntary nonprofit agency, or a proprietary agency as set forth in Sections 12302 and 12302.1.

(15) Assume the financial risk associated with the cost of payroll and associated activities set forth in paragraph (10).

(b) IHSS recipients receiving services through managed care health plans shall retain all of the following:

(1) The responsibilities as the employer of the IHSS provider for the purposes of hiring, firing, and supervising their provider of choice as set forth in Section 12301.6.

(2) The ability to appeal any action relating to his or her application for or receipt of services pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(3) The right to employ a provider applicant who has been convicted of an offense specified in Section 12305.87 by submitting a waiver of the exclusion.

(4) The ability to request a reassessment pursuant to Section 12301.1.

(c) The department and the State Department of Social Services, along with the counties, managed care health plans, consumers, advocates, and other stakeholders, shall develop a referral process and informational materials for the appeals process that is applicable to home- and community-based services plan benefits authorized by a managed care health plan. The process established by this paragraph shall ensure ease of access for consumers.

(d) For services provided through managed care health plans, the IHSS provider shall continue to adhere to the requirements set forth in subdivisions (a) and (b) of Section 12301.24, subdivision (a) of Section 12301.25, subdivision (a) of Section 12305.81, and subdivision (a) of Section 12306.5.

(e) In accordance with Section 14186.2, as the provision of IHSS transitions to managed care health plans in a phased-in approach, the State Department of Social Services shall do all of the following:

(1) Retain program administration functions, in coordination with the department, including policy development, provider appeals and general exceptions, and quality assurance and program integrity for the IHSS program in accordance with Article 7 (commencing with Section 12300) of Chapter 3.

(2) Perform the obligations on behalf of the recipient as employer relating to workers' compensation as set forth in Section 12302.2.

(3) Retain responsibilities related to the hearing process for IHSS recipient appeals as set forth in Chapter 7 (commencing with Section 10950) of Part 2.

(4) Continue to have access to and provide confidential recipient data necessary for the administration of the program.

SEC. 14. Section 14186.36 is added to the Welfare and Institutions Code, to read:

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

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

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

(c) (1) No later than June 1, 2013, the department, the State Department of Social Services, and the California Department of Aging shall establish a stakeholder workgroup to develop the universal assessment process, including a universal assessment tool, for home- and community-based services, as defined in subdivision (a) of Section 14186.1. The stakeholder workgroup shall include, but not be limited to, consumers of IHSS and other home- and community-based services and their authorized representatives, managed care health plans, counties, IHSS, MSSP, and CBAS providers, and legislative staff. The universal assessment process shall be used for all home- and community-based services, including IHSS. In developing the process, the workgroup shall build upon the IHSS uniform assessment process and hourly task guidelines, the MSSP assessment process, and other appropriate home- and community-based assessment tools.

(2) (A) In developing the universal assessment process, the departments described in paragraph (1) shall develop a universal assessment tool that will inform the universal assessment process and facilitate the

development of plans of care based on the individual needs of the consumer. The workgroup shall consider issues including, but not limited to, the following:

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

(ii) The criteria for reassessment.

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

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

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

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

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

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

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

(d) No later than March 1, 2014, the department, the State Department of Social Services, and the California Department of Aging shall report to the Legislature on the stakeholder workgroup's progress in developing the universal assessment process, and shall identify the counties and beneficiary categories for which the universal assessment process may be implemented pursuant to subdivision (e).

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

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

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

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

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

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

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

(g) Until existing law relating to the IHSS assessment process pursuant to Article 7 (commencing with Section 12300) of Chapter 3 is amended, beneficiaries shall have the option to request an additional assessment using the previous assessment process for those home- and community-based services and to receive services according to the results of the additional assessment.

(h) No later than nine months after the implementation of the universal assessment process, the department, the State Department of Social Services, and the California Department of Aging, in consultation with

stakeholders, shall report to the Legislature on the results of the initial use of the universal assessment process, and may identify proposed additional beneficiary categories or counties for expanded use of this process and any necessary changes to provide statutory authority for the continued use of the universal assessment process. These departments shall report annually thereafter to the Legislature on the status and results of the universal assessment process.

(i) The provisions of this section shall remain operative only until July 1, 2017.

SEC. 15. (a) In the event 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 six-month enrollment period in the demonstration project pursuant to Section 14132.275 of the Welfare and Institutions Code, effective March 1, 2013, this act shall become inoperative, the amendments made to the sections amended by this act shall be inoperative, and the sections added by this act shall be inoperative. The director shall execute a declaration attesting to these facts and post it on the department's Internet Web site.

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

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

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

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

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

SEC. 17. In the event the director decides to entirely forego the provision of services as specified in Section 14186.4 of the Welfare and Institutions Code, Section 6531.5 of the Government Code and Sections 12300.5, 12300.6, and 12300.7 of the Welfare and Institutions Code as added by this act shall cease to be implemented except as follows:

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

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

SEC. 18. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 19. The sum of one thousand dollars ($1,000) is hereby appropriated from the General Fund to the State Department of Health Care Services for administration.

SEC. 20. This act shall become operative only if Assembly Bill 1468 or Senate Bill 1008 of the 2011–12 Regular Session of the Legislature is enacted and takes effect.

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

SB-1008 Public social services: Medi-Cal. (2011-2012)

Senate Bill No. 1008

CHAPTER 33

An act to amend Sections 14132.275, 14182, 14183.6, and 14301.1 of, to add Sections 14132.276, 14182.16, 14182.17, and 14301.2 to, and to add Article 5.7 (commencing with Section 14186) of Chapter 7 of Part 3 of Division 9 to, the Welfare and Institutions Code, relating to public social services, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 27, 2012. Filed with Secretary of State June 27, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1008, Committee on Budget and Fiscal Review. Public social services: Medi-Cal.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. One of the methods by which these services are provided is pursuant to contracts with various types of managed care health plans.

Existing federal law provides for the federal Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which, either through employment by the recipient, by or through contract by the county, by the creation of a public authority, or pursuant to a contract with a nonprofit consortium, qualified aged, blind, and disabled persons receive services enabling them to remain in their own homes.

Existing law, to the extent that federal financial participation is available, and pursuant to a demonstration project or waiver of federal law, requires the department to establish pilot projects in up to 4 counties, to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs. Existing law requires the department to, not sooner than March 1, 2011, identify health care models that may be included in a pilot project, develop a timeline and process for selecting, financing, monitoring, and evaluating the pilot projects, and provide this timeline and process to certain committees of the Legislature.

This bill would revise terminology used in these provisions and would require the department to establish demonstration sites, as defined, in up to 8 counties not sooner than March 1, 2013. This bill would require the department to enter into a memorandum of understanding (MOU), with specified terms and conditions, with the federal Centers for Medicare and Medicaid Services (CMS) in developing the process for selecting, financing, monitoring, and evaluating the health care models for the demonstration project, and would require the department to require a demonstration site, as defined, to comply with specified requirements to the extent that the terms and conditions of the MOU do not address the specific selection, financing, monitoring, and evaluation criteria. This bill would require the department, with exceptions, to enroll dual eligible beneficiaries into a demonstration site unless the dual eligible beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled in specific entities, as specified.

Existing law requires the department to seek a demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors, persons with disabilities, and children with special health care needs. Existing law authorizes the department to require certain seniors and persons with disabilities to be assigned as mandatory enrollees into managed care health plans, and requires the department to meet prescribed conditions if the department exercises this authority.

This bill would add prescribed conditions to those requirements, including, among other things, requiring the department to provide to a beneficiary a written notice with prescribed information when a request for exemption from plan enrollment is denied.

This bill would require the department, in addition to the dual eligibles demonstration project, to assign Medi-Cal beneficiaries who have dual eligibility in Medi-Cal and the Medicare Program as mandatory enrollees into new and existing Medi-Cal managed care health plans, as defined, for their Medi-Cal benefits in counties participating in the demonstration project unless the beneficiary is exempt, as specified. This bill would authorize the department to contract with additional managed care health plans to provide Medi-Cal services in specified counties. This bill would require the department to ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries residing in counties participating in the demonstration project who are dual eligible beneficiaries and receive Medi-Cal benefits and services through the demonstration project or through mandatory enrollment in managed care health plans, and for Medi-Cal beneficiaries who receive long-term services and supports, as defined, and would require the department to perform various duties before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services, as specified.

This bill would provide that it is the intent of the Legislature that long-term services and supports be provided through managed care health plans in counties participating in the demonstration project. This bill would require that Medi-Cal long-term services and supports, including in-home supportive services, community-based adult services, Multipurpose Senior Services Program (MSSP) services, and skilled nursing facility and subacute care services, as specified, be covered services under managed care health plan contracts and would, with some exceptions, provide that these services only be available through managed care health plan contracts to beneficiaries residing in counties participating in the demonstration project. This bill would provide that home- and community-based services plan benefits, as defined, may be covered services under managed care health plan contracts for beneficiaries in counties participating in the demonstration project.

Existing law requires the State Department of Health Care Services to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and authorizes the department to establish health-plan- and county-specific rates, as specified.

This bill would apply those provisions to specified managed care organizations and to the capitation rates the department pays on and after the effective date of this bill under any managed care health plan contract, as specified.

This bill would, to the extent consistent with federal law, authorize the department to defer payments to Medi-Cal managed care health plans and providers, as applicable, contracting with the department, as specified, which are payable to the plans during the final month of the 2012–13 state fiscal year, if certain conditions are satisfied.

This bill would provide that specified sections shall become inoperative under certain circumstances.

This bill would appropriate $1,000 from the General Fund to the State Department of Health Care Services for administration.

This bill would become operative only if AB 1496 or SB 1036 of the 2011–12 Regular Session is enacted and takes effect.

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

Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14132.275 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) (1) (A) Except for the exemptions provided for in this section, the department shall enroll dual eligible beneficiaries into a demonstration site unless the beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled on or before June 1, 2013, in a managed care organization licensed under the

Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS or in any entity with a contract with the department pursuant to Chapter 8.75 (commencing with Section 14591).

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

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

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

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

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

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

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

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

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

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

(i) The beneficiary has a prior diagnosis of end-stage renal disease. This clause shall not apply to beneficiaries diagnosed with end-stage renal disease subsequent to enrollment in the demonstration project. The director

may, with stakeholder input and federal approval, authorize beneficiaries with a prior diagnosis of end-stage renal disease in specified counties to voluntarily enroll in the demonstration project.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) Notwithstanding Section 10231.5 of the Government Code, the department shall conduct an evaluation, in partnership with CMS, to assess outcomes and the experience of dual eligibles in these demonstration sites and shall provide a report to the Legislature after the first full year of demonstration operation, and annually

thereafter. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code. The department shall consult with stakeholders regarding the scope and structure of the evaluation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 2. Section 14132.276 is added to the Welfare and Institutions Code, to read:

14132.276. For nursing facility services provided under the demonstration project as established in Section 14132.275, to the extent these services are authorized under the demonstration project, the following shall apply:

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

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

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

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

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

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

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

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

SEC. 3. Section 14182 of the Welfare and Institutions Code is amended to read:

14182. (a) (1) In furtherance of the waiver or demonstration project developed pursuant to Section 14180, the department may require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new or existing managed care health plans. To the extent that

enrollment is required by the department, an enrollee's access to fee-for-service Medi-Cal shall not be terminated until the enrollee has been assigned to a managed care health plan.

(2) For purposes of this section:

(A) "Other health coverage" means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program, or health coverage under contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(B) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200).

(b) In exercising its authority pursuant to subdivision (a), the department shall do all of the following:

(1) Assess and ensure the readiness of the managed care health plans to address the unique needs of seniors or persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure the managed care health plans provide access to providers that comply with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(3) Develop and implement an outreach and education program for seniors and persons with disabilities, not currently enrolled in Medi-Cal managed care, to inform them of their enrollment options and rights under the demonstration project. Contingent upon available private or public dollars other than moneys from the General Fund, the department or its designated agent for enrollment and outreach may partner or contract with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting seniors and persons with disabilities in understanding their health care coverage options. Contracts entered into or amended pursuant to this paragraph shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and any implementing regulations or policy directives.

(4) At least three months prior to enrollment, inform beneficiaries who are seniors or persons with disabilities, through a notice written at no more than a sixth grade reading level, about the forthcoming changes to their delivery of care, including, at a minimum, how their system of care will change, when the changes will occur, and who they can contact for assistance with choosing a delivery system or with problems they encounter. In developing this notice, the department shall consult with consumer representatives and other stakeholders.

(5) Implement an appropriate cultural awareness and sensitivity training program regarding serving seniors and persons with disabilities for managed care health plans and plan providers and staff in the Medi-Cal Managed Care Division of the department.

(6) Establish a process for assigning enrollees into an organized delivery system for beneficiaries who do not make an affirmative selection of a managed care health plan. The department shall develop this process in consultation with stakeholders and in a manner consistent with the waiver or demonstration project developed pursuant to Section 14180. The department shall base plan assignment on an enrollee's existing or recent utilization of providers, to the extent possible. If the department is unable to make an assignment based on the enrollee's affirmative selection or utilization history, the department shall base plan assignment on factors, including, but not limited to, plan quality and the inclusion of local health care safety net system providers in the plan's provider network.

(7) Review and approve the mechanism or algorithm that has been developed by the managed care health plan, in consultation with their stakeholders and consumers, to identify, within the earliest possible timeframe, persons with higher risk and more complex health care needs pursuant to paragraph (11) of subdivision (c).

(8) Provide managed care health plans with historical utilization data for beneficiaries upon enrollment in a managed care health plan so that the plans participating in the demonstration project are better able to assist beneficiaries and prioritize assessment and care planning.

(9) Develop and provide managed care health plans participating in the demonstration project with a facility site review tool for use in assessing the physical accessibility of providers, including specialists and ancillary

service providers that provide care to a high volume of seniors and persons with disabilities, at a clinic or provider site, to ensure that there are sufficient physically accessible providers. Every managed care health plan participating in the demonstration project shall make the results of the facility site review tool publicly available on their Internet Web site and shall regularly update the results to the department's satisfaction.

(10) Develop a process to enforce legal sanctions, including, but not limited to, financial penalties, withholding of Medi-Cal payments, enrollment termination, and contract termination, in order to sanction any managed care health plan in the demonstration project that consistently or repeatedly fails to meet performance standards provided in statute or contract.

(11) Ensure that managed care health plans provide a mechanism for enrollees to request a specialist or clinic as a primary care provider. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollee.

(12) Ensure that managed care health plans participating in the demonstration project are able to provide communication access to seniors and persons with disabilities in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English-proficient, or non-English speaking, and that all managed care health plans are in compliance with applicable cultural and linguistic requirements.

(13) Ensure that managed care health plans participating in the demonstration project provide access to out-of-network providers for new individual members enrolled under this section who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

(14) Ensure that managed care health plans participating in the demonstration project comply with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

(15) Ensure that the medical exemption criteria applied in counties operating under Chapter 4.1 (commencing with Section 53800) or Chapter 4.5 (commencing with Section 53900) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations are applied to seniors and persons with disabilities served under this section.

(16) Ensure that managed care health plans participating in the demonstration project take into account the behavioral health needs of enrollees and include behavioral health services as part of the enrollee's care management plan when appropriate.

(17) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set (HEDIS) or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance (NCQA) Structure and Process measures, or both.

(18) Conduct medical audit reviews of participating managed care health plans that include elements specifically related to the care of seniors and persons with disabilities. These medical audits shall include, but not be limited to, evaluation of the delivery model's policies and procedures, performance in utilization management, continuity of care, availability and accessibility, member rights, and quality management.

(19) Conduct financial audit reviews to ensure that a financial statement audit is performed on managed care health plans annually pursuant to the Generally Accepted Auditing Standards, and conduct other risk-based audits for the purpose of detecting fraud and irregular transactions.

(20) Ensure that managed care health plans maintain a dedicated liaison to coordinate with the department, affected providers, and new individual members for all of the following purposes:

(A) To ensure a mechanism for new members to obtain continuity of care as described in paragraph (13).

(B) To receive notice, including that a new member has been denied a medical exemption as described in paragraph (15), which is required to include the name or names of the requesting provider, and ensure that the

provider's ability to treat the member is continued as described in paragraphs (11) and (13), if applicable, or, if not applicable, ensure the member is immediately referred to a qualified provider or specialty care center.

(C) To assist new members in maintaining an ongoing relationship with a specialist or specialty care center when the specialist is contracting with the plan and the assigned primary care provider has approved a standing referral pursuant to Section 1374.16 of the Health and Safety Code.

(21) Ensure that written notice is provided to the beneficiary and the requesting provider if a request for exemption from plan enrollment is denied. The notice shall set out with specificity the reasons for the denial or failure to unconditionally approve the request for exemption from plan enrollment. The notice shall inform the beneficiary and the provider of the right to appeal the decision, how to appeal the decision, and if the decision is not appealed, that the beneficiary shall enroll in a Medi-Cal plan and how that enrollment shall occur. The notice shall also include information of the possibility of continued access to an out-of-network provider pursuant to paragraph (13). A beneficiary who has not been enrolled in a plan shall remain in fee-for-service Medi-Cal if a request for an exemption from plan enrollment or appeal is submitted, until the final resolution. The department shall also require the plans to ensure that these beneficiaries receive continuity of care.

(22) Develop a process to track a beneficiary who has been denied a request for exemption from plan enrollment and to notify the plan, if applicable, of the denial, including information identifying the provider. Notwithstanding paragraph (12) of subdivision (c), the plan shall immediately refer the beneficiary for a risk assessment survey and an individual care plan shall be developed within 10 days, including authorization for 30 days of continuity of prescription drugs.

(c) Prior to exercising its authority under this section and Section 14180, the department shall ensure that each managed care health plan participating in the demonstration project is able to do all of the following:

(1) Comply with the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area. Managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and Internet Web site.

(3) Assess the health care needs of beneficiaries who are seniors or persons with disabilities and coordinate their care across all settings, including coordination of necessary services within and, where necessary, outside of the plan's provider network.

(4) Ensure that the provider network and informational materials meet the linguistic and other special needs of seniors and persons with disabilities, including providing information in an understandable manner in plain language, maintaining toll-free telephone lines, and offering member or ombudsperson services.

(5) Provide clear, timely, and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits. Each managed care health plan participating in the demonstration project shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(6) Solicit stakeholder and member participation in advisory groups for the planning and development activities related to the provision of services for seniors and persons with disabilities.

(7) Contract with safety net and traditional providers as defined in subdivisions (hh) and (jj) of Section 53810, of Title 22 of the California Code of Regulations, to ensure access to care and services. The managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(8) Inform seniors and persons with disabilities of procedures for obtaining transportation services to service sites that are offered by the plan or are available through the Medi-Cal program.

(9) Monitor the quality and appropriateness of care for children with special health care needs, including children eligible for, or enrolled in, the California Children Services Program, and seniors and persons with disabilities.

(10) Maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(11) At the time of enrollment apply the risk stratification mechanism or algorithm described in paragraph (7) of subdivision (b) approved by the department to determine the health risk level of beneficiaries.

(12) (A) Managed care health plans shall assess an enrollee's current health risk by administering a risk assessment survey tool approved by the department. This risk assessment survey shall be performed within the following timeframes:

(i) Within 45 days of plan enrollment for individuals determined to be at higher risk pursuant to paragraph (11).

(ii) Within 105 days of plan enrollment for individuals determined to be at lower risk pursuant to paragraph (11).

(B) Based on the results of the current health risk assessment, managed care health plans shall develop individual care plans for higher risk beneficiaries that shall include the following minimum components:

(i) Identification of medical care needs, including primary care, specialty care, durable medical equipment, medications, and other needs with a plan for care coordination as needed.

(ii) Identification of needs and referral to appropriate community resources and other agencies as needed for services outside the scope of responsibility of the managed care health plan.

(iii) Appropriate involvement of caregivers.

(iv) Determination of timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level.

(13) (A) Establish medical homes to which enrollees are assigned that include, at a minimum, all of the following elements, which shall be considered in the provider contracting process:

(i) A primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions.

(ii) Care management and care coordination for the beneficiary across the health care system including transitions among levels of care.

(iii) Provision of referrals to qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the managed care health plan.

(iv) Use of clinical data to identify beneficiaries at the care site with chronic illness or other significant health issues.

(v) Timely preventive, acute, and chronic illness treatment in the appropriate setting.

(vi) Use of clinical guidelines or other evidence-based medicine when applicable for treatment of beneficiaries' health care issues or timing of clinical preventive services.

(B) In implementing this section, and the Special Terms and Conditions of the demonstration project, the department may alter the medical home elements described in this paragraph as necessary to secure the increased federal financial participation associated with the provision of medical assistance in conjunction with a health home, as made available under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and codified in Section 1945 of Title XIX of the federal Social Security Act. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to alter medical home elements under this section at least five days in advance of taking this action.

(14) Perform, at a minimum, the following care management and care coordination functions and activities for enrollees who are seniors or persons with disabilities:

(A) Assessment of each new enrollee's risk level and health needs shall be conducted through a standardized risk assessment survey by means such as telephonic, Web-based, or in-person communication or by other means as determined by the department.

(B) Facilitation of timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including referrals to address any physical or cognitive barriers to access.

(C) Active referral to community resources or other agencies for needed services or items outside the managed care health plans responsibilities.

(D) Facilitating communication among the beneficiaries' health care providers, including mental health and substance abuse providers when appropriate.

(E) Other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(d) Except in a county where Medi-Cal services are provided by a county organized health system, and notwithstanding any other provision of law, in any county in which fewer than two existing managed care health plans contract with the department to provide Medi-Cal services under this chapter, the department may contract with additional managed care health plans to provide Medi-Cal services for seniors and persons with disabilities and other Medi-Cal beneficiaries.

(e) Beneficiaries enrolled in managed care health plans pursuant to this section shall have the choice to continue an established patient-provider relationship in a managed care health plan participating in the demonstration project if his or her treating provider is a primary care provider or clinic contracting with the managed care health plan and agrees to continue to treat that beneficiary.

(f) The department may contract with existing managed care health plans to operate under the demonstration project to provide or arrange for services under this section. Notwithstanding any other provision of law, the department may enter into the contract without the need for a competitive bid process or other contract proposal process, provided the managed care health plan provides written documentation that it meets all qualifications and requirements of this section.

(g) This section shall be implemented only to the extent that federal financial participation is available.

(h) (1) The development of capitation rates for managed care health plan contracts shall include the analysis of data specific to the seniors and persons with disabilities population. For the purposes of developing capitation rates for payments to managed care health plans, the director may require managed care health plans, including existing managed care health plans, to submit financial and utilization data in a form, time, and substance as deemed necessary by the department.

(2) (A) Notwithstanding Section 14301, the department may incorporate, on a one-time basis for a three-year period, a risk-sharing mechanism in a contract with the local initiative health plan in the county with the highest normalized fee-for-service risk score over the normalized managed care risk score listed in Table 1.0 of the Medi-Cal Acuity Study Seniors and Persons with Disabilities (SPD) report written by Mercer Government Human Services Consulting and dated September 28, 2010, if the local initiative health plan meets the requirements of subparagraph (B). The Legislature finds and declares that this risk-sharing mechanism will limit the risk of beneficial or adverse effects associated with a contract to furnish services pursuant to this section on an at-risk basis.

(B) The local initiative health plan shall pay the nonfederal share of all costs associated with the development, implementation, and monitoring of the risk-sharing mechanism established pursuant to subparagraph (A) by means of intergovernmental transfers. The nonfederal share includes the state costs of staffing, state contractors, or administrative costs directly attributable to implementing subparagraph (A).

(C) This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.

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

(j) Persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary care case management (PCCM) plan in operation on that date, may select that PCCM plan or a successor health care plan that is licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2

(commencing with Section 1340) of Division 2 of the Health and Safety Code) to provide services within the same geographic area that the PCCM plan served on January 1, 2010.

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

(l) Consistent with state law that exempts Medi-Cal managed care contracts from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code, and in order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process is necessary for contracts entered into or amended pursuant to this section. The contracts and amendments entered into or amended pursuant to this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and the requirements of State Administrative Management Manual Memo 03-10. The department shall make the terms of a contract available to the public within 30 days of the contract's effective date.

(m) In the event of a conflict between the Special Terms and Conditions of the approved demonstration project, including any attachment thereto, and any provision of this part, the Special Terms and Conditions shall control. If the department identifies a specific provision of this article that conflicts with a term or condition of the approved waiver or demonstration project, or an attachment thereto, the term or condition shall control, and the department shall so notify the appropriate fiscal and policy committees of the Legislature within 15 business days.

(n) In the event of a conflict between the provisions of this article and any other provision of this part, the provisions of this article shall control.

(o) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14500) not in conflict with this article or with the terms and conditions of the demonstration project shall apply to this section.

(p) To the extent that the director utilizes state plan amendments or waivers to accomplish the purposes of this article in addition to waivers granted under the demonstration project, the terms of the state plan amendments or waivers shall control in the event of a conflict with any provision of this part.

(q) (1) Enrollment of seniors and persons with disabilities into a managed care health plan under this section shall be accomplished using a phased-in process to be determined by the department and shall not commence until necessary federal approvals have been acquired or until June 1, 2011, whichever is later.

(2) Notwithstanding paragraph (1), and at the director's discretion, enrollment in Los Angeles County of seniors and persons with disabilities may be phased-in over a 12-month period using a geographic region method that is proposed by Los Angeles County subject to approval by the department.

(r) A managed care health plan established pursuant to this section, or under the Special Terms and Conditions of the demonstration project pursuant to Section 14180, shall be subject to, and comply with, the requirement for submission of encounter data specified in Section 14182.1.

(s) (1) Commencing January 1, 2011, and until January 1, 2014, the department shall provide the fiscal and policy committees of the Legislature with semiannual updates regarding core activities for the enrollment of seniors and persons with disabilities into managed care health plans pursuant to the pilot program. The semiannual updates shall include key milestones, progress toward the objectives of the pilot program, relevant or necessary changes to the program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and other key activities related to the mandatory enrollment of seniors and persons with disabilities into managed care health plans. The department shall also include updates on the transition of individuals into managed care health plans, the health outcomes of enrollees, the care management and coordination process, and other information concerning the success or overall status of the pilot program.

(2) (A) The requirement for submitting a report imposed under paragraph (1) is inoperative on January 1, 2015, pursuant to Section 10231.5 of the Government Code.

(B) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(t) The department, in collaboration with the State Department of Social Services and county welfare departments, shall monitor the utilization and caseload of the In-Home Supportive Services (IHSS) program before and during the implementation of the pilot program. This information shall be monitored in order to identify the impact of the pilot program on the IHSS program for the affected population.

(u) Services under Section 14132.95 or 14132.952, or Article 7 (commencing with Section 12300) of Chapter 3 that are provided to individuals assigned to managed care health plans under this section shall be provided through direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium, in accordance with and subject to the requirements of Section 12302 or 12301.6, as applicable.

(v) The department shall, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans.

(w) The department shall suspend new enrollment of seniors and persons with disabilities into a managed care health plan if it determines that the managed care health plan does not have sufficient primary or specialty providers to meet the needs of their enrollees.

SEC. 4. Section 14182.16 is added to the Welfare and Institutions Code, to read:

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

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

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

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

(3) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200).

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

(5) "Out-of-network Medi-Cal provider" means a health care provider that does not have an existing contract with the beneficiary's managed care health plan or its subcontractors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) The department may implement an intergovernmental transfer arrangement with a public entity that elects to transfer public funds to the state to be used solely as the nonfederal share of Medi-Cal payments to managed care health plans for the provision of services to dual eligible beneficiaries pursuant to Section 14182.15.

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

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

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

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

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

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

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

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

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

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

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

SEC. 5. Section 14182.17 is added to the Welfare and Institutions Code, to read:

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

(b) The department shall ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries residing in counties participating in the demonstration project pursuant to Section 14132.275 who are either of the following:

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

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

(c) The department shall develop an enrollment process to be used in counties participating in the demonstration project pursuant to Section 14132.275 to do the following:

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

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

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

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

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

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

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

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

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

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

(F) Ensure that managed care health plans have policies and procedures in effect to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration project. These

policies shall include, but not be limited to, the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including a determination of which beneficiaries require information about their transition supply, and, within the first 90 days of coverage under a new plan, provide for a temporary fill when the beneficiary requests a refill of a nonformulary drug.

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

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

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

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

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

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

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

(I) The plan choices.

(II) Continuity of care provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

disorders treatment services.

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

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

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

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

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

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

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

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

(G) Maintain a liaison and provide access to out-of-network providers, for up to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have an ongoing relationship with a provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible beneficiary enrolled in Medicare Part A who only receives primary and specialty care services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that furnish ancillary services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) Submit to the Legislature the following information:

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

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

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

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

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

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

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

(D) No later than 90 days prior to the initial plan enrollment date of the demonstration project pursuant to the provisions of Sections 14132.275, 14182.16, and of Article 5.7 (commencing with Section 14186), assess and report to the fiscal and appropriate policy committees of the Legislature on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries and Medi-Cal only seniors and persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48. The report shall also include an assessment of the readiness of the managed care health plans in each county participating in the demonstration project to have met the requirements set forth in paragraphs (1) to (9), inclusive.

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

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

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

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

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

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

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

planning process.

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

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

(iii) Finalize rates and comprehensive contracts between the department and participating health plans to facilitate effective outreach, enroll network providers, and establish benefit packages. The plan rates and contracts shall be provided to the appropriate fiscal and policy committees of the Legislature and posted on the department's Internet Web site so that they are readily available to the public.

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

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

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

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

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

(ix) Develop continuity of care procedures.

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

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

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

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

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

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

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

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

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section and any applicable

federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 6. Section 14183.6 of the Welfare and Institutions Code is amended to read:

14183.6. The department shall enter into an interagency agreement with the Department of Managed Health Care to have the Department of Managed Health Care, on behalf of the department, conduct financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in the demonstration project, and provide consumer assistance to beneficiaries affected by the provisions of Sections 14182.16 and 14182.17. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of these core activities. The department shall not delegate its authority under this division as the single state Medicaid agency to the Department of Managed Health Care.

SEC. 7. Article 5.7 (commencing with Section 14186) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.7. Long-Term Services and Supports Integration

14186. (a) It is the intent of the Legislature that long-term services and supports (LTSS) be covered through managed care health plans in counties participating in the demonstration project authorized under Section 14132.275.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Effective January 1, 2015, or 19 months after commencement of beneficiary enrollment in the demonstration project authorized pursuant to Section 14132.275, whichever is later, MSSP services shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n et seq.) to a benefit administered and allocated by managed care health plans.

It is also the intent of the Legislature that the provisions of this article and the demonstration project pursuant to Section 14132.275 shall apply to dual eligible and Medi-Cal-only beneficiaries enrolled in MSSP. It is the further intent of the Legislature that managed care health plans shall work in collaboration with MSSP providers to begin development of an integrated, person-centered care management and care coordination model that works within the context of managed care, and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model.

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

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

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

(b) "Long-term services and supports" or "LTSS" means all of the following:

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

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

(3) Multipurpose Senior Services Program (MSSP) services include those services approved under a federal home- and community-based services waiver or, beginning January 1, 2015, equivalent services.

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

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

(c) "Home- and community-based services (HCBS) plan benefits" may include in-home and out-of-home respite, nutritional assessment, counseling, and supplements, minor home or environmental adaptations, habilitation, and other services that may be deemed necessary by the managed care health plan, including its care coordination team. The department, in consultation with stakeholders, may determine whether health plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits. The grievance process for these benefits shall be the same

process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450, and Sections 1368 and 1368.1 of the Health and Safety Code.

(d) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200). For the purposes of this article, "managed care health plan" shall not include an individual, organization, or entity that enters into a contract with the department to provide services pursuant to Chapter 8.75 (commencing with Section 14591) or the Senior Care Action Network.

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

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

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

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

(3) Beneficiaries who are not mandatorily enrolled in a managed care health plan pursuant to Section 14182 or pursuant to the exemptions provided for in subdivision (c) shall not be required to receive LTSS, other than CBAS, through a managed care health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Beneficiaries enrolled in a home- and community-based waiver that is a Medi-Cal benefit under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n), except for persons enrolled in Community-Based Adult Services, Multipurpose Senior Services Program services, or a Section 1915(c) waiver for developmentally disabled persons.

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

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

14186.3. (a) (1) No sooner than July 1, 2012, Community-Based Adult Services (CBAS) shall be a Medi-Cal benefit covered under every managed care health plan contract and available only through managed care health plans. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in a managed care health plan in order to receive those services, except for beneficiaries exempt under subdivision (c) of Section 14186.2 or in counties or geographic regions where Medi-Cal benefits are not covered through managed care health plans. Notwithstanding subdivision (a) of Section 14186.2 and pursuant to the provisions of an approved federal waiver or plan amendment, the provision of CBAS as a Medi-Cal benefit through a managed care health plan shall not be limited to counties participating in the demonstration project authorized under Section 14132.275.

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

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

(2) Notwithstanding the implementation date authorized in paragraph (1) of subdivision (a) of Section 14186.2, beginning no sooner than June 1, 2013, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, and concluding January 1, 2015, or 19 months after commencement of beneficiary enrollment in the demonstration project authorized pursuant to Section 14132.275, or on the date that any necessary federal approvals or waivers are obtained, whichever is later:

(A) Multipurpose Senior Services Program (MSSP) services shall be a Medi-Cal benefit available only through managed care health plans, except for beneficiaries exempt under subdivision (c) of Section 14186.2.

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

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

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

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

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

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

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

(4) (A) Effective January 1, 2015, or 19 months after the commencement of beneficiary enrollment in the demonstration project authorized pursuant to Section 14132.275, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, MSSP services in counties where the demonstration project authorized under Section 14132.275 is implemented shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n et seq.) to a benefit administered and allocated by managed care health plans.

(B) No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the transition plan.

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

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

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

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

(4) When a managed care health plan has authorized services in a facility and there is a change in the beneficiary's condition under which the facility determines that the facility may no longer meet the needs of the beneficiary, the beneficiary's health has improved sufficiently so the resident no longer needs the services provided by the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, the managed care health plan shall arrange and coordinate a discharge of the beneficiary and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

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

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

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

(c) To implement this article, the department may contract with public or private entities. Contracts, or amendments to current contracts, entered into under this article may be on a noncompetitive bid basis and shall be exempt from all of the following:

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

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

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

(4) Review or approval of feasibility study reports and the requirements of Sections 4819.35 to 4819.37, inclusive, and Sections 4920 to 4928, inclusive, of the State Administrative Manual.

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

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

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

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

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

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

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

SEC. 8. Section 14301.1 of the Welfare and Institutions Code is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 9. Section 14301.2 is added to the Welfare and Institutions Code, to read:

14301.2. The director may defer payments to Medi-Cal managed care health plans contracting with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089) of this chapter, or Chapter 8 (commencing with Section 14200) or Chapter 8.75 (commencing with Section 14591), the Senior Care Action Network Health Plan, and Medi-Cal managed care health plan providers, as applicable, which are payable to the plans during the final month of the 2012–13 state fiscal year. This section may be implemented only to the extent consistent with federal law.

SEC. 10. (a) In the event 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 six-month enrollment period in the demonstration project pursuant to paragraph (2) of subdivision (l) of Section 14132.275, effective March 1, 2013, Sections 14132.275, 14182.16, and 14182.17, and Article 5.7 (commencing with Section 14186) of Chapter 7 shall become inoperative. The director shall execute a declaration of these facts and post it on the department's Internet Web site.

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

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

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

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

SEC. 11. It is the intent of the Legislature for the demonstration project pursuant to Section 14132.275 of the Welfare and Institutions Code to expand statewide within three years of the start of the demonstration project. Expansion beyond the initial eight counties shall be contingent upon statutory authorization and a subsequent budget appropriation.

SEC. 12. The sum of one thousand dollars ($1,000) is hereby appropriated from the General Fund to the State Department of Health Care Services for administration.

SEC. 13. This act shall become operative only if Assembly Bill 1496 or Senate Bill 1036 of the 2011–12 Regular Session of the Legislature is enacted and takes effect.

SEC. 14. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.