Department of Health Care Services
Proposed Trailer Bill Language

~~Care Coordination~~ Coordinated Care Initiative for Medi-Cal Beneficiaries

Add uncodified section to the Welfare and Institutions Code as follows:

SEC. 1. The Legislature finds and declares that:

Medicare and Medi-Cal are the primary government sponsored insurance programs available to seniors and persons with disabilities. ~~The federally run Medicare program and the state run Medi-Cal program (that is 50% funded by the federal government) provide services to a population that is usually more at risk for poor health outcomes and decreased quality of care through different eligibility, benefit administration and funding mechanisms.~~ The federally run Medicare program is the primary insurer/payer for full benefit dual eligible beneficiaries and covers medically necessary health services such as: physician, hospital and limited skilled nursing services. Medi-Cal which is 50% funded by the federal government and is the secondary insurer/payer and typically covers Medicare out-of-pocket cost-sharing and services not covered by Medicare, as well as services provided after Medicare benefits have been exhausted. Partial benefit dual eligible beneficiaries are eligible for either Medicare Part A or Part B and Medi-Cal is responsible for those services not covered by Medicare. Medi-Cal only Seniors and Persons with Disabilities are not eligible for Medicare. Most long-term care costs for all of these beneficiaries are paid for by Medi-Cal, including longer nursing home stays and home and community-based services designed to prevent institutionalization.

Within the Medi-Cal program, approximately 7 percent of beneficiaries account for 75 percent of program costs – primarily institutional services. These beneficiaries, many of whom are seniors or persons with disabilities, are frequently dually eligible for and enrolled in the federal Medicare program and the state-run Medi-Cal program. Dual eligible beneficiaries represent some of the most expensive and medically complex beneficiaries receiving health care coverage funded by a combination of public funds, including federal funds, state General Funds, and in some cases county funds.
In addition, many of these beneficiaries ~~are~~ also ~~eligible for~~ receive personal care services through the In Home Supportive Services (IHSS) program, which is locally administered and includes a county share-of-cost. Consequently, the current system attempts to address the health care needs of the most chronically ill and vulnerable beneficiaries through a variety of providers that receive funding from multiple government sources. This uncoordinated system creates incentives that encourage Medicare and Medi-Cal to shift costs to one another, with beneficiaries often caught in the middle.

The Coordinated Care Initiative is designed to address these concerns. Coordinating care and eliminating detrimental incentives would achieve significant efficiencies, improve care, and reduce system costs related to hospital and nursing home

admissions. Coordinating care for these beneficiaries generally means having ~~the same~~ a managed care health plan responsible for the coordination and delivery of all benefits for a beneficiary. This will achieve significant efficiencies, generate savings, and improve care for beneficiaries. In addition to aligning program responsibility and financial incentives, this proposal has two broad themes:

- Promoting Coordinated Care—Managed care done well results in high-quality care. This Initiative provides managed care plans with a blended payment consisting of federal, state, and county funds and responsibility for delivering the full range of health and social services. The plans will combine strong beneficiary protections with centralized responsibility for the broader continuum of care. This combination will promote accountability and coordination, align financial incentives, and improve care continuity across medical, long-term services, and behavioral health services.

- Enhancing Access to Home and Community-Based Services—Within an expanded system of coordinated care, it is critical to better integrate medical services with the full continuum of long-term services and supports, including IHSS, Community-Based Adult Services, Multipurpose Senior Services Programs (MSSP), and skilled nursing facility services, and coordinate behavioral health services which are partially funded by counties. Improving access to and coordination of these services is sound policy and can improve their health outcomes.

The proposal to improve care coordination will be phased in over a three-year period starting January 1, 2013. In the first year, in up to ten counties participating in the dual demonstration project, ~~demonstration sites~~ managed care health plans will be responsible for paying ~~and arranging~~ for and coordinating the full-continuum of Medi-Cal and Medicare services, for both dual eligible beneficiaries and Medi-Cal only Seniors and Persons with Disabilities. Further, all LTSS shall be provided through Medi-Cal managed care health plans. All ~~other~~ dual eligible beneficiaries who are not living in these ~~demonstration site~~ counties but who reside in counties where Medi-Cal managed care plans exist will be mandatorily enrolled in Medi-Cal managed care plans for their wraparound Medi-Cal benefits starting January 2013 on a phased-in basis. These plans will be financially at risk and have the responsibility to arrange for Medi-Cal benefits. There will be no change in the way Medicare benefits are provided in the first year for non-demonstration site dual eligible beneficiaries.

In the second year, the Initiative will be expanded geographically, as demonstration sites will be added, and as additional Medi-Cal managed care plans become ready to take on ~~additional~~ responsibility for Medicare benefits for dual eligible beneficiaries and long-term services and supports for all Medi-Cal beneficiaries.

Finally, beneficiaries in the proposed managed care expansion counties (proposed to begin in June 2013), will transition in calendar years 2014 through 2015 for both Medi-Cal and Medicare benefits.

Delivering long-term services and supports through Medi-Cal managed care plans raises important issues including, but not limited to, (1) consumer protections for individuals newly receiving acute, long-term care, and home and community-based services within managed care plans; (2) the need to develop a ~~uniform~~ universal assessment process ~~tool~~ for home and community-based services; ~~and~~ (3) consumer choice and protection when selecting providers, including IHSS and other plan network providers; and (4) counties will continue their current role in conducting assessments and determining IHSS authorized hours for consumers.

Further, design and implementation should incorporate the following beneficiary protection principles:

1) The coordinated care delivery system, including provider networks, care coordination, assessment tools, and metrics for monitoring and evaluating the quality of care, should be beneficiary-focused.

2) Coordinated care models should provide access to all necessary long-term services and supports and align financial incentives around increasing the availability of and access to home and community-based services.

3) The appeals process for dual eligible beneficiaries in the demonstration project should be the same for both Medicare and Medi-Cal complaints.

4) Care continuity is a critical issue when proposing new delivery models. There should be policies and procedures to ensure smooth care transitions.

5) Beneficiaries should be provided information about enrollment rights and options, plan benefits and rules, and care plan elements, and have the ability to make informed choices. This information should be delivered in a format and language accessible to enrollees.

6) Beneficiaries should be able to self-direct their care and be able to hire, fire, and manage their IHSS ~~personal care~~ provider~~worker~~.

7) Oversight and monitoring elements should be coordinated and complementary between federal, state, and local agencies. Agency authority should be clear and systems should be developed to respond quickly to problems.

8) Coordinated care delivery models should be culturally and linguistically appropriate and physically accessible to all enrollees.

SEC. 2 Section 14132.275 of the Welfare & Institutions Code is amended to read:

14132.275. (a) The department shall seek federal approval to establish ~~pilot~~ the demonstration project~~s~~ 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 Centers for Medicare and

Medicaid Services and demonstration sites to operate the Medicare and Medicaid benefits in ~~component of~~ a ~~pilot~~ demonstration project that is overseen by the State as a delegated Medicare benefit administrator, and may enter into financing arrangements with the federal Centers for Medicare and Medicaid Services to share in any Medicare program savings generated by the ~~operation of any pilot~~ demonstration project.
(b) After federal approval is obtained, the department shall establish the ~~pilot~~ demonstration project~~s~~ that enables dual eligible beneficiaries to receive a continuum of services ~~and~~ that maximizes access to and ~~the~~ 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 ~~needed~~. The purpose of the ~~pilot~~ demonstration project~~s~~ is to ~~develop effective health care models that~~ 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~~sepilot~~ demonstration project~~s~~ may also include additional services as approved through a demonstration project or waiver, or a combination thereof.
(c) For purposes of this section:
(1) "Dual eligible beneficiary" means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is eligible for medical assistance under the Medi-Cal State Plan.
(2) "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 federal Medicare program.
(3) "Demonstration site" means a managed care health plan that is selected to participate in the demonstration project under the capitated payment model or a managed fee-for-service model.
(4) A "capitated payment model" means an agreement entered into between the federal Centers for Medicare and Medicaid Services (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 Medicare Part C of Title 42 of the United States Code (commencing with Section 1395w-21) and Part D of Title 42 of the United States Code (commencing with Section 1395w-101), and 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 14146.1, behavioral health services, and any additional services offered by the demonstration site.
(5) A "managed fee-for-service model" means an agreement entered into by CMS and the State, in which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medi-Cal.
(~~c~~d) No~~t~~ sooner than March 1, 2011, the department shall identify health care models that may be included in a ~~pilot~~ demonstration project, shall develop a timeline and process for selecting, financing, monitoring, and evaluating ~~these pilot~~ demonstration

sites ~~projects~~, and shall provide this timeline and process to the appropriate fiscal and policy committees of the Legislature. The department may implement these ~~pilot~~ demonstration sites ~~projects~~ in phases.

(e) The department shall provide the fiscal and policy committees of the Legislature with a copy of any report submitted to the Centers for Medicare and Medicaid Services that may be required under the demonstration project.

(~~d~~f) Goals for the ~~pilot~~ demonstration project~~s~~ shall include all of the following:

(1) Coordinate~~e~~~~ing~~Medi-Cal and ~~benefits,~~ Medicare benefits, ~~or both~~, across health care settings and improve~~ing~~ the continuity of care across acute care, long-term care, and home- and community-based services settings using a person-centered approach.

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

(3) Maximize~~e~~~~ing~~ the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional care.

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

(~~e~~g) (1) Beginning January 1, 2013,~~Pilot~~demonstration sites~~projects~~ shall be established in up to ~~four~~ ten 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). In determining the counties in which to establish a ~~pilot~~ demonstration site ~~project~~, the director shall consider the following:

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

(B~~2~~) A local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the ~~pilot~~ demonstration site ~~project~~.

(2) As of January 1, 2013, the department may expand the number of demonstration sites into additional counties as long as the demonstration site meets the terms and conditions of the memorandum of understanding referenced in subdivision (i) of this section and any additional criteria developed by the department. While enrollment in the demonstration sites may not begin in more than 10 counties in 2013, the Department may specify in 2013 any number of qualified counties as participating in the demonstration for purposes of obtaining federal approval for expansions that will occur in 2014 and 2015.

(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 the Centers for Medicare and Medicaid Services.

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

(1)(A) Reimbursement methods for a managed fee-for-service model.

(B) Reimbursement methods for a capitated payment model. Under the capitated payment model, the demonstration sites shall:

(i) 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.
(ii) Be in good financial standing and meet Knox-Keene Act licensure requirements, if applicable.
(iii) Meet quality measures which may include Medi-Cal and Medicare health care Effectiveness Data and Information Set measures and other quality measures determined or developed by the department and the Center for Medicare and Medicaid Services.
(iv) Demonstrate a local stakeholder process that includes dual eligible beneficiaries, managed care health plans, providers, county health and human service agencies, and other interested stakeholders that advise and consult with the demonstration site in the development, implementation, and continued operation of the demonstration project.
(v) Pay providers according to the prevailing Medicare fee schedule and payment methodology for Medicare benefits, and the full Medi-Cal rates for Medi-Cal benefits, according to federal and state payment rules. If the demonstration site is using an alternative payment methodology to pay for services, such as a capitated rate, the payment must be actuarially equivalent to the same or similar payments for services in Medicare or Medi-Cal fee-for-service.
(2) Uniform 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 the federal Centers for Medicare and Medicaid Services, in consultation with the demonstration site and stakeholders.
(5) Uniform Medicare and Medi-Cal appeals and hearing process.
(6) Unified marketing requirements and combined review process by the department and Centers for Medicare and Medicaid Services.
(7) Combined quality management and consolidated reporting process by the department and Centers for Medicare and Medicaid Services.
(8) Procedures related to combined federal and State contract management to ensure access, quality, program integrity, and financial solvency of the demonstration site.
(9) Implementation of the provisions of Section 14182.17 that are applicable to beneficiaries simultaneously eligible for full-scope benefits under Medi-Cal and the federal Medicare Program**.**
(j) The department shall comply with and enforce the terms and conditions of the memorandum of understanding with CMS, as specified in subdivision (h). However, to the extent that the terms and conditions do not address the specific selection, financing, monitoring, and evaluation criteria listed below, the department may require the demonstration site to do all of the following:
(1) Comply with additional site readiness criteria specified by the department.
(2) Comply with long-term services and supports requirements in accordance with Article 4.6.

(3) Forgo charging premiums, coinsurance, copayments, and deductibles for Medicare Part C and D services.
(4) Comply with the provisions of Section 14182.17 that are applicable to beneficiaries simultaneously eligible for full-scope benefits under both Medi-Cal and the federal Medicare Program.
(k) In the event of a conflict between the memorandum of understanding and this section, the memorandum of understanding shall control.
(~~f~~l) 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 the Government Code.
~~(g) Services under Section 14132.95, 14132.952, or Article 7 (commencing with Section 12300) of Chapter 3 that are provided under the pilot projects established by 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.~~
~~(h) Notwithstanding any other provision of state law, the department may require that dual eligibles be assigned as mandatory enrollees into managed care plans established or expanded as part of a pilot project established under this section. Mandatory enrollment in managed care for dual eligibles shall be applicable to the beneficiary's Medi-Cal benefits only.Dual eligibles shall have the option to enroll in a Medicare Advantage special needs plan (SNP) offered by the managed care plan established or expanded as part of a pilot project established pursuant to (e).To the extent that mandatory enrollment is required, any requirement of the department and the managed care health plans, and any requirement of continuity of care protections for enrollees, as specified in Section 14182, shall be applicable to this section. Dual eligibles shall have the option to forgo receiving Medicare benefits under a pilot project. Nothing in this section shall be interpreted to reduce benefits otherwise available under the Medi-Cal program or the Medicare Program.~~
~~(i) For purposes of this section, a "dual eligible" means an individual who is simultaneously eligible for full scope benefits under Medi-Cal and the federal Medicare Program.~~
(m)(1) Notwithstanding any other provision of state law, the department shall enroll dual eligible beneficiaries into a demonstration site unless the dual eligible beneficiary makes an affirmative choice to opt-out of enrollment. Dual eligible beneficiaries who opt-out of enrollment into a demonstration site may choose to remain enrolled in ~~Original~~ **fee-for service** Medicare or a Medicare Advantage Plan for their Medicare benefits, but will be mandatorily enrolled into a Medi-Cal managed care health plan pursuant to Section 14182.16. In addition, ~~P~~persons meeting requirements for Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591)or Primary Care Case Management pursuant to Article 2.9 (commencing with Section 14088), may select either of these managed care health plans for their Medicare and Medi-Cal benefits if one is available in that county.

(2) To the extent that federal approval is obtained, the department may require that any beneficiary, upon enrollment in a demonstration site, shall remain enrolled in the Medicare portion of the demonstration on a mandatory basis for six months from the date of initial enrollment. After the sixth month, the department shall permit a dual eligible beneficiary to enroll in a different demonstration site, a different Medicare Advantage plan, fee-for-service Medicare, or PACE for their Medicare benefits. 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:
(A) The dual eligible beneficiary demonstrates an existing relationship with the provider prior to enrollment into a demonstration site;
(B) The provider is willing to accept payment from the demonstration site based on the current Medicare fee schedule; and,
(C) The demonstration site would not otherwise exclude the provider from their provider network due to documented quality of care concerns.
(4) The department, with stakeholder input, may exempt specific categories of dual eligible beneficiaries from the enrollment requirements in this section.
(n) Notwithstanding Section 10231.5 of the Government Code, in partnership with the Centers for Medicare and Medicaid Services, the department shall conduct an evaluation to assess the outcomes and the experience of dual eligible beneficiaries in these ~~pilot~~ demonstration sites ~~projects~~ and shall provide a report to the Legislature after the first full year of ~~pilot~~ 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.
(o) This section shall be implemented only if and to the extent that federal financial participation or funding is available ~~to establish these pilot projects~~.
(p) 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. 3 Article 4.6 (commencing with Section 14146) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institution Code, to read:

Article 4.6.Long-Term Services and Supports Integration

14146 (a) It is the intent of the Legislature that the State's most vulnerable populations have long-term services and supports integrated into managed care health plans to produce better health. In furtherance of this intent:
~~(b) In furtherance of this intent:~~

(b) (1) Persons receiving health care services through Medi-Cal shall 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, ~~behavioral~~, long-term services and supports and enhanced care management, shall be provided through Medi-Cal managed care health plans in order to eliminate system inefficiencies and align incentives with positive health care outcomes.
(3) Medi-Cal benefits shall be provided to most Medi-Cal beneficiaries through managed care health plans by expanding Medi-Cal managed care to every county in the State.
(4) To the extent possible, for Medi-Cal beneficiaries also enrolled in the federal Medicare program, the department shall work with the federal government to coordinate financing and incentives and permit managed care health plans to coordinate the health care provided under both health care systems.
(5) The health care choices made by Medi-Cal beneficiaries shall be considered with regard to:
(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, decision, 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 settings;
(E) Self-directing their care by being able to hire, fire, and manage their ~~personal care worker~~ IHSS provider.
(F)Being assured by the department~~'s~~ and coordinating departments of their oversight of the quality ~~of care~~ of these coordinated health care services.
(6) Counties will continue to have a role in the assessment of beneficiaries for ~~long term services and supports~~IHSS.
(c) Although the following process may vary by year and by county, and depending on stakeholder input, to reflect the fact that many beneficiaries are already enrolled in Medi-Cal Managed Care, the intent of the Legislature shall be accomplished by a Coordinated Care Initiative that includes the following components:
(1) In the first year, beginning January 1, 2013, the Initiative will be implemented in up to ten counties participating in the Dual Demonstration Project pursuant to Section 14132.275. Long-Term Services and Supports (LTSS) shall be provided through managed care health plans in these counties. Managed care health plans shall develop and expand care coordination practices with counties, nursing facilities, and other home and community-based services, and share best practices. Managed care health plans shall establish care coordination teams as needed. These care coordination teams would include the consumer, health plan, and county social services agency, and may include others. In these counties, managed care health plans shall work with the counties as needed on case coordination and assessments for IHSS. County agencies shall continue IHSS assessment and authorization processes, including final determinations of IHSS hours on behalf of the Med-Cal managed care health plans and in accordance with statutory provisions for IHSS eligibility. These assessments shall be

coordinated with care coordination teams where applicable, as established by Section 14146.3(e)(1)(D). A grievance and appeals process and other protections for IHSS consumers will remain in place. Health plans may authorize additional home and community-based services, including IHSS hours.
(2) In the second year, beginning January 1, 2014, the provisions of the Initiative described in (c)(1) will be expanded to the remaining counties in which, as of July 1, 2012, Medi-Cal services are provided through managed care health plans, as the Dual Demonstration Project is expanded to those counties. In addition, managed care health plans in these counties would be permitted to hire or incorporate staff from a Multipurpose Senior Services Program (MSSP) into the managed care health plan's care management team.
(3) In the third year, beginning January 1, 2015, provisions of the Initiative as described in (c)(1) and (2), will be expanded to all remaining counties, which by then will have managed care health plans, established under a separate provision of this Initiative.
(4) In addition, in the third year, beginning January 1, 2015, managed care health plans and their contractors and home and community-based service providers, shall utilize the new universal assessment tool described in Section 14146.3(f) for all home and community-based services as defined in Section 14146.1(c). The managed care health plans shall have responsibility for the provision of all long-term services and supports except that the managed care plans through the care coordination teams shall work with counties as needed on the case coordination and assessments for IHSS. This new universal assessment tool shall build upon the IHSS Uniform Assessment process, Hourly Task Guidelines and other appropriate home and community-based assessment tools, and will be in addition to the assessment process specified in Section 14182.17(b)(2), used by managed care health plans when beneficiaries initially enroll in managed care. In addition to the activities set forth in Section 14146.3(e)(1)(G), county agencies shall continue IHSS assessment and authorization processes, including final determinations of IHSS hours on behalf of the Med-Cal managed care health plans and in accordance with statutory provisions for IHSS eligibility. A grievance and appeals process and other protections for IHSS consumers will remain in place.
(5) Although this Article does not alter the current structure of the county public authority and nonprofit consortium as set forth in Section 12301.6, the state may at a future date, work with stakeholders and seek other alternatives.

14146.1 For purposes of this article:
(a) "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), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200). "Managed care health plan" does not mean 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.
(b) "Long-term services and supports" (LTSS) are:

(1) In-Home Supportive Services (IHSS) provided pursuant to Sections 12300 et. seq, 14132.95, 14132.952 and 14132.956;
(2) Community Based Adult Services (CBAS) only if and to the extent that the department obtains all approvals for federal waivers or amendments making Community Based Adult Services a Medi-Cal benefit;
(3) Multipurpose Senior Services Program (MSSP) services approved under a federal home and community-based services waiver;
(4) Skilled nursing facility services and subacute care services established under Section 14132(c). However, services provided by any category of intermediate care facility for the developmentally disabled shall not be considered long-term services and supports; and,
(5) Any home and community-based services waiver service that is a Medi-Cal benefit under an approved federal Section 1915(c) (of the Social Security Act) waiver, and only to the extent that the department obtains any necessary federal approvals or waivers to include that service as a long-term service and support.
(c) "Home and community-based services" includes services provided pursuant to paragraphs (1), (2), (3) and (5) subdivision (b) of this Section.
(d) "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 federal Medicare Program [Title XVIII of the 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.

14146.2(a)(1) In conformity with the Legislative intent stated in Section 14146, all Medi-Cal long-term services and supports described in Section 14146.1(b), shall be covered services under managed care health plan contracts and shall be available only through managed care health plans in counties where managed care is available, using a phased-in approach to implement this Article on a statewide basis, with exceptions as specified in subdivision (d). The department shall pay managed care health plans using a capitation rate setting 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 all Medi-Cal benefits.
(2) The transition of the provision of LTSS through a managed care health plan shall occur after the department obtains any federal approvals through necessary federal waivers or amendments, or state plan amendments, and as follows:
(A) Beginning no sooner than January 1, 2013, the department may expand provision of LTSS through managed care health plans into counties participating in the demonstration project for dual eligible beneficiaries pursuant to Section 14132.275.
(B) Beginning no sooner than January 1, 2014, the department may expand provision of LTSS through managed care health plans into all counties not included in subparagraph (A) where Medi-Cal benefits are provided through managed care health plans at the time of enactment of this Article.
(C) Beginning no sooner than January 1, 2015, the department may expand provision of LTSS through managed care health plans into all remaining counties.

(b)(1) The schedule described in subdivisions (a)(2) of this section shall apply to all provisions of Article 4.6, except where specified otherwise.
(2) The provisions of Article 4.6 shall only apply in those counties where long-term services and supports are provided through managed care health plans, pursuant to the schedule described in subdivisions (a)(2) of this section, except where otherwise specified. Counties where long-term services and supports are not provided through managed care health plans are not subject to the provisions of Article 4.6.
(c)(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, according to the schedule described in subdivision (a).
(2) At the director's sole discretion, in consultation with coordinating departments, 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, or over a twelve-month period or other phased approach.

(d) The provisions of this Article shall not apply to:
(1) Medi-Cal beneficiaries described below who will continue to receive any medically necessary Medi-Cal benefits including LTSS through fee-for-service Medi-Cal. The beneficiaries receiving services through fee-for-service Medi-Cal must:
(A) Except in counties with County Organized Health Systems operating pursuant to Article 2.8 (commencing with Section 14087.5), have other health coverage;
(B) Receive services through any State foster care program including the Foster Care Program as described in Article 5 (commencing with Section 11400) Chapter 2, Part 3, Division 9 of the Welfare and Institutions Code, unless the beneficiary is already receiving services through a managed care health plan;
(C) Be Indians receiving Medi-Cal services in accordance with Section 55110 of Title 22 of the California Code of Regulations; or
(D) Not be eligible for enrollment in managed care health plans for any other reason determined by the department.
(2) Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE), pursuant to Chapter 8.75 (commencing with Section 14591), or Primary Care Case Management pursuant to Article 2.9 (commencing with Section 14088).

14146.3(a)(1) Community-Based Adult Services (CBAS): No sooner than July 1, 2012, Community-Based Adult Services 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 Community-Based Adult Services will be required to enroll in a managed care health plan in order to receive this service, except for beneficiaries exempt under 14146.2(d), or in counties or geographic regions where Medi-Cal benefits are not provided through managed care health plans.
(2) Managed care health plans will be required to determine a member's medical need for this service using the assessment tool and eligibility criteria established pursuant to the provisions of an approved federal waiver or amendments and will be required to approve the number of days of attendance and monitor treatment plans of their members. Managed care health plans will also be required to re-authorize Community-

Based Adult Services in compliance with criteria established pursuant to the provisions of an approved federal waiver or amendment requirements.

(b)(1) MSSP: Beginning January 1, 2013, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, MSSP shall be a Medi-Cal benefit available only through managed care health plans, except for beneficiaries exempt under 14146.2(d), and in counties where MSSP exist, managed care health plans shall contract with county or non-profit organizations who are designated providers of the MSSP for the provision of MSSP case management and waiver services.

(2) Beginning January 1, 2014, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, managed care health plans shall continue to contract with counties or non-profit organizations for MSSP case management and waiver services, or may integrate this program into the managed care health plan's case management services by offering to hire MSSP case managers, who are registered nurses and social workers, to become members of the plan's care management teams if the managed care health plan determines that the case managers meet the managed care health plan's employment requirements.

(c)(1) Nursing facility services and subacute facility services: Beginning January 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.

(d) Home and community-based services waiver services: Beginning January 1, 2013, on the date that any necessary federal approvals or waivers are obtained, whichever is later, home and community-based services waiver services that are Medi-Cal benefits under an approved federal Section 1915(c) (of the Social Security Act) waiver shall be Medi-Cal benefits available only through managed care health plans.

(e)(1) IHSS: Beginning January 1, 2013, and in accordance with the county implementation schedule described in Section 14146.2(a)(2) IHSS shall be a Medi-Cal benefit available through managed care health plans. Managed care health plans shall provide IHSS in accordance with the standards and requirements set forth in Article 7 (commencing with Section 12300). Specifically, managed care health plans shall:
(A) Ensure access to provision of, and payment for IHSS for individuals who meet the eligibility criteria for IHSS.
(B) Continue to allow recipients, as the employer, to select, engage, direct, supervise, schedule and terminate IHSS providers in accordance with Section 12301.6.
(C) Assume all financial liability for payment of IHSS services for recipients receiving said services pursuant to managed care.
(D) Create a care coordination team, as needed, that would 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.

(E) Ensure compliance with all requirements set forth in Section 14132.956 and any resulting state plan amendment.
(F) Adhere to quality assurance provisions, individual data and other standards and requirements as specified by the California Department of Social Services including state and federal quality assurance requirements.
(G) Enter into contracts with the county agencies to perform the following activities:
(i) Assess each recipient's initial and continuing need for services pursuant to Sections 12301.1, 12301.2, 12301.21 and 12309.1, and approve and authorize IHSS hours on behalf of the Med-Cal managed care health plans in accordance with statutory provisions for IHSS eligibility. Assessments shall be conducted in coordination with care coordination teams as established by subparagraph (D) of this paragraph. Plans may contract with counties for additional assessments and enter into performance-based contracts;
(ii) Enroll providers, conduct provider orientation and retain enrollment documentation pursuant to Sections 12301.24 and 12305.81;
(iii) Conduct criminal background checks on all potential providers who are not listed on the registry of a public authority or nonprofit consortium and exclude providers consistent with the provisions set forth in Sections 12305.81, 12305.86 and 12305.87;
(iv) Refer all providers to the appropriate public authority or non-profit consortium, for the purposes of wages and benefits
(vii) Administer health benefits for providers of IHSS as established pursuant to paragraph 2 of subdivision (b) of this section.
(viii) Pursue overpayment recovery pursuant to Section 12305.83;
(vi) Perform quality assurance activities including routine case reviews, home visits and detecting and reporting fraud pursuant to Section 12305.71;
(H) Enter into a contract with the county IHSS public authority or nonprofit consortium to perform the following activities as defined in Sections 12301.6 as well as those specified below:
(i) Provide training for providers and recipients;
(ii) Provide assistance to IHSS recipients in finding eligible providers through the establishment of a provider registry;
(iii) Conduct criminal background checks on all potential registry providers and exclude providers consistent with the provisions set forth in Sections 12301.6, 12305.81 and 12305.87;
(iv) Engage in collective bargaining for the purposes of wages, hours, and other terms and conditions of employment.
(I) Enter into a contract with the California Department of Social Services to perform the following activities:
(i) Pay wages to IHSS providers;
(ii) Perform obligations of the member as the employer including unemployment compensation, disability benefits, and federal and state income taxes and federal old age survivor's and disability insurance through the State's payroll system for IHSS in accordance with the provisions set forth in Sections 12302.2 and 12317;
(iii) 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 provisions set forth in Section 12303.7, the monthly cash-payment-in-

advance provisions set forth in Section 12304, and the direct-deposit program set forth in Section 12304.4.
(iv) Share recipient and provider data with managed care health plans for members who are receiving IHSS.
(v) Provide an option for managed care health plans to participate in the county social services agency quality monitoring activities of the California Department of Social Services, for recipients who are plan members .
(J) In concert with the department, timely reimburse the California Department of Social Services to meet payroll and other obligations of the beneficiary as the employer, including unemployment compensation, disability benefits and federal and state income taxes and federal old-age survivors and disability insurance benefits through the State's payrolling system.
(K) 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.
(L) 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.
(M) Utilize wages established by the county public authority or nonprofit consortium established in Section 12301.6.
(N) Provide a grievance process for any applicant or recipient of IHSS who is dissatisfied with any action relating to his or her application for or receipt of IHSS and for any provider who is dissatisfied with any action taken regarding enrollment or disqualification from participation in the program.
(O) Assume the financial risk associated with the cost of payroll and associated activities set forth in subparagraph (I) of this paragraph.

(2) IHSS recipients receiving services through managed care health plans shall retain the following roles:
(A) The responsibility 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;
(B) The ability to appeal any action relating to his or her application for or receipt of services;
(C) 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;
(D) The ability to request a reassessment when a change in circumstances has occurred pursuant to Section 12301.1.

(3) For services provided through managed care health plans, the IHSS provider will be required to continue to adhere to the requirements set forth in Sections 12301.24(a), 12301.24(b), 12301.25(a), 12305.81(a), 12301.86 and 12306.5(a).

(4) In accordance with Section 14146.2, as the provision of IHSS transitions to managed care health plans in a phased-in approach the California Department of Social Services shall:

(A) Retain administrative functions, in coordination with the department, including, policy development, provider appeals/general exceptions, quality assurance and program integrity for the IHSS program in accordance with Section 12300 et. seq.
(B) Perform the obligations on behalf of the recipient as employer relating to workers' compensation as set forth in Section 12302.2.

(5) Beginning January 1, 2015, in addition to the activities set forth in subparagraph (G) of paragraph 1 of this subdivision, county social services agencies shall continue IHSS assessment and authorization processes, including final determinations of IHSS hours. County assessment will utilize the universal assessment tool as described in subdivision (f) of this section, upon completion of the stakeholder process, system design and testing, and county training. The managed care health plans shall have responsibility for providing IHSS based on input from, and determinations made by, the care coordination team.

(f)(1) No later than June 1, 2013, the department, in conjunction with the California 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. The stakeholder workgroup shall include, but not be limited to, consumers and their representatives, managed care health plans, counties, 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, Hourly Task Guidelines and other appropriate home and community-based assessment tools.
(2) Beginning no sooner than January 1, 2015, upon completion of design, development, system testing, and training, and after the department obtains any federal approvals through necessary federal waivers or amendments, or state plan amendments, managed care health plans, counties and other home and community-based services providers shall utilize the universal assessment tool. Any assessment changes affecting IHSS will require the ability to be automated in the Case Management, Information and Payrolling System.

14146.4. (a) Counties shall continue to participate in the non-federal share of IHSS costs as specified in Sections 10101.1, 12306 and 12306.1 equal to the amount that would have been expended by the counties in the absence of the Coordinated Care Initiative. The expenditure level for each county shall be known as the County IHSS Maintenance of Effort (MOE). The MOE level for each county shall become operative upon the county's transition of LTSS to managed care, pursuant to paragraph (2) of subdivision (a) of Section 14146.2.

(b) The base year of IHSS expenditures and a statewide annual growth factor for purposes of determining each county's MOE shall be determined by the Department of Finance in consultation with the California State Association of Counties.

(c) To the extent total IHSS expenditures increase in a given county as a result of changes other than growth in caseload or authorized hours, the state and county shall pay the the non-federal portion of the cost increase in accordance with the provisions of Sections 10101.1,12306 and 12306.1. The county share of these expenditures shall be included in the County IHSS MOE, in addition to the amount established under subdivisions (a) and (b).

14146.5 (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 provision of law, the director retains the sole 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 will be jeopardized. In the event the director discontinues the provision of services in the manner specified in this article, all contracts implemented pursuant to this article shall accordingly be terminated.
(c) To implement this section, the department may contract with public or private entities. Contracts, or amendments to current contracts, entered into under this part may be on a noncompetitive bid basis and shall be exempt from the following:
(l) 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 State Administrative Manual Sections 4819.35 to 4819.37, inclusive, and Sections 4920 to 4928, inclusive.
(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the Department of Health Care Services and 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 stakeholder, including beneficiaries, providers and advocates.
(e) Beginning January 1, 2012 until December 31, 2014, the department shall provide the fiscal and 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) Notwithstanding any other provision of law, if the Director of the Department of Finance determines, annually on September 1, that the actions pursuant to this article have caused utilization changes that result in higher state costs than would have occurred absent the provisions of this article, after fully offsetting implementation and

administrative costs, the Department of Finance shall notify the Joint Legislative Budget Committee, department, the State Department of Social Services, and the Department of Aging, and the Departments upon receiving such notification shall discontinue the provision of services specified in this article. Ninety days after this certification the sections of this article shall cease to be effective.

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

14182.16. (a) The department may require Medi-Cal beneficiaries who have dual eligibility in Medi-Cal and the federal Medicare Program to be assigned as mandatory enrollees into new or existing Medi-Cal managed care health plans.

(b) For purposes of this section and Section 14182.17:

(1) "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).

(2) "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 Medicare, or health coverage under a contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(3) “Dual eligible beneficiary” means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and/or Part B of Title 42 of the United States Code (commencing with Section 1395j) and is eligible for medical assistance under the Medi-Cal State Plan.

(4) “Full benefit dual eligible beneficiary” means an individual who is eligible for benefits under Parts A and B of Title 42 of the United States Code (commencing with Sections 1395c and j) and Part D of Title 42 of the United States Code (commencing with Section 1395w-101) and is eligible for medical assistance under the Medi-Cal State Plan.

(5) “Partial dual eligible beneficiary” means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) but not under Part B of Title 42 of the United States Code (commencing with Section 1395j), or who is eligible for Part B but not under Part A, and is eligible for medical assistance under the Medi-Cal State Plan.

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

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

(1) Has other health coverage,

(2) Is enrolled in the California Children’s Services (CSS) pilot program pursuant to Section 14182.2.

(3) Receives services through a foster care program including the Foster Care Program as described in Article 5 (commencing with Section 11400) Chapter 2, Part 3, Division 9 of the Welfare and Institutions Code.
(4) Is an Indian receiving Medi-Cal services in accordance with Section 55110 of Title 22 of the California Code of Regulations.
(45) Is not eligible for enrollment in managed care health plans for any other reason determined by the department.
(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 federal 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 over a twelve-month period. The phased-in enrollment shall not commence until all necessary federal approvals have been obtained or until January 1, 2013, whichever is later.
(f) Beginning no sooner than June 1, 2013, or on the date that all necessary federal approvals or waivers are obtained, whichever is later, in order to implement this section through managed care health plans on a statewide basis, the department may expand the provision of Medi-Cal benefits through managed care health plans under Section 14087.3, into any county in which Medi-Cal benefits are provided on a fee-for-service basis.
(g) 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.
(h) 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 that are available to dual eligible beneficiaries, including long-term care services and supports, the department may contract with additional managed care health plans to provide Medi-Cal services.
(i) For partial dual eligible beneficiaries, the department will inform these beneficiaries of their rights to continuity of care from out-of-network Medi-Cal providers pursuant to subparagraph (G) of paragraph (6) of subdivision (b) of Section 14182.17,and that the need for medical exemption criteria applied in 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.
(j) The department may contract with existing managed care health plans 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 and Section 14182.17.
(k) 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.

(l) 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 may require all managed care health plans, including existing managed care health plans, to submit financial, encounter, and utilization data in a form, time, and substance as deemed necessary by the department. Failure to submit the required data will result in imposition of penalties pursuant to Section 14182.1.

(m) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14590), may select a PACE plan if one is available in that county.

(o) Except for dual eligible beneficiaries participating in the demonstration pursuant to Section 14132.275, persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary care 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.

(p) 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 beneficiary pursuant to Section 14182.15.

(q) 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.

(r) 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 non-exclusive basis and a non-competitive 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.

(s) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590) not in conflict with this section or with the terms and conditions of the waiver shall apply to this section.

(t) To the extent that the director utilizes state plan amendments, waivers, or demonstration authority to accomplish the purposes of this section, the terms of the

state plan amendments, waivers, or demonstration memorandum of understanding shall control in the event of a conflict with any provision of this section.
(u) The department shall, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans.
(v) 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 services and supports to meet the needs of their enrollees.

SEC. 5. Section 14182.17 of the Welfare & Institutions Code is added, to read:
14182.17(a) The department shall ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries who are dual eligible beneficiaries, as that term is defined in Section 14182.16(b), and receive Medi-Cal benefits and services through the demonstration project established pursuant to Section 14132.275, through mandatory enrollment in managed care health plans pursuant to Section 14182.16, and for all Medi-Cal beneficiaries who receive long-term services and supports pursuant to Article 4.6 (commencing with Section 14146).
(b) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (a),the department shall:
(1) Ensure timely and appropriate communications with beneficiaries as follows:
(A) 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.
(B) Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.
(C) 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.
(D) Ensure that managed care health plans 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.
(E) Contingent upon available private or public dollars 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.
(F) At least ninety days prior to enrollment, inform dual eligible beneficiaries through a notice written at no more than a sixth grade reading level that includes, at a minimum, how their 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.
(2) Require that managed care health plans perform an assessment process that does, at a minimum, all of the following:

(A) Assesses each new enrollee's risk level and needs conducted under a risk assessment process by means such as telephonic, Web-based, or in-person communication, review of utilization/claims processing data, or by other means as determined by the department, with a particular focus on identifying those that 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, where 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 Section 14182(b)(7) 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) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.
(3) Develop an enrollment process to transition dual eligible beneficiaries into a managed care health plan that matches their Medicare Advantage plan in compliance with federal regulations, including Medicare Improvements for Patients and Providers Act of 2008 (PL 110-275), except that the enrollment provisions of Section 14132.275 shall apply to dual eligible beneficiaries that enroll in the demonstration project. If a dual eligible beneficiary is in fee-for-service Medicare, they will have a choice of Medi-Cal managed care health plans, if applicable. If they do not choose a managed care health plan, they will be enrolled in a health plan by the department, using an algorithm developed by the department.
(4) Ensure that managed care health plans arrange for primary care as follows:
(A) Forgo interference with a beneficiary choice of primary care physician under Medicare, and does not assign a full-benefit dual eligible to a primary care physician unless it is determined through the risk stratification and assessment process that assignment is necessary, ~~as necessary,~~ in order to properly coordinate the care of the beneficiary or upon beneficiary request.
(B) Assign a primary care physician to a partial dual eligible receiving primary and/or specialty care through the Medi-Cal managed care plan.
(C) Provide a mechanism for partial dual eligible enrollees to request a specialist or clinic as a primary care provider when 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 enrollee.
(5) 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, outcomes-based approach to care planning, consistent with the CMS Model of Care approach.
(B) Adhere to a beneficiary's determination about the appropriate involvement of their medical providers and caregiver, according to Health Insurance Portability and Accountability Act of 1996 (P.L. 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.
(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 member's primary care physician, if appropriate, and other medical professionals to provide care management and enhanced care management, as applicable, particularly for members in need of or receiving long-term services and supports.
(F) Consider behavioral health needs of enrollees and coordinate such services with the county mental health department as part of the enrollee's care management plan when appropriate.
(G) Facilitate the beneficiaries' ability to access appropriate community resources and other agencies.
(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 will monitor and support beneficiaries in the community to avoid further institutionalization.
(6) Ensure that 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 laws, 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 enrollees, at a minimum, by phone, written material, and Internet Web site, upon request.
(D) Monitor an appropriate provider network that includes an adequate number of accessible facilities within each service area.
(E) 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.
(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) 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 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 dual eligible enrolled in Medicare Part A who only receives primary and specialty care services through a Medi-Cal managed care health plan will be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for twelve months after enrollment. This paragraph does 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 dual eligibles that are receiving primary and specialty care through the Medi-Cal managed care plan.
(I) Employ care managers directly or contract with non-profit or proprietary organizations, including organizations that are now operating under ~~Multipurpose Senior Services Program~~MSSP, in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.
(7) Ensure that the managed care health plan addresses 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 the beneficiaries' health 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 enrollee, including referrals to address any physical or cognitive barriers to access.
(8) Ensure that managed care health plans provide, at a minimum, and in addition to other statutory and contractual requirements, a grievance and appeal process as follows:
(A) Provide 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.
(B) Comply with a unified Medicare and Medi-Cal appeals and grievance process developed by the department, as applicable.
(9) 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, as follows:

(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) Beginning January 1, 2013, develop 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 their 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) Monitor the quality and appropriateness of care for children with special health care needs who are also dual eligible beneficiaries, including children eligible for, or enrolled in, the California Children's Services Program.
(10) Develop and implement an organized delivery system to improve care coordination and integration of health care services for Medi-Cal beneficiaries in a transparent manner as follows:
(A) Beginning January 1, 2013, provide the fiscal and policy committees of the Legislature with a copy of any report submitted to CMS pursuant to the approved federal waiver described in Section 14180.
(B) Develop a stakeholder engagement plan and submit that plan to the Legislature within 30 days of enactment of this section, and engage stakeholders in the planning for and implementation of this section.
(C) Assess and report to the fiscal and policy committees of the Legislature on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) through (8), inclusive, of subdivision (b) of Section 14087.48.
(D) Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development activities related to the provision of services for dual eligible beneficiaries.
(c) 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.
(d) 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.

(e)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 non-exclusive basis and a non-competitive 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.

SEC. 6 Section 14301.2 of the Welfare and Institutions code is added, to read:

14301.2. (a) 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), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200), Chapter 8.75 (commencing with Section 14591), and the Senior Care Action Network, and Medi–Cal managed care health plan providers, as applicable, which are payable to the plans during the final month of State fiscal year 2012 - 13. This section may be implemented only to the extent consistent with federal law.
(b) The director of the Department of Health Care Services shall not defer the payments referenced in subdivision (a) to Medi-Cal managed care health plans or providers unless a statute permitting the director to do all of the following is enacted on or before July 1, 2012:

(1) Expand the number of counties for the dual eligible demonstration project pursuant to Section 14132.275.
(2) Require beneficiaries dually eligible for Medicare and Medi-Cal to enroll in managed care for Medi-Cal benefits pursuant to Section 14182.16.
(3) Require beneficiaries using long-term services and supports to receive those services through managed care pursuant to Article 4.6.

The state Controller may establish at the request of the Department of Finance a new budget act item for federal funding provided for the purpose of implementing the demonstration established under Section 14132.275.

SEC 7 Section 14132.957 of the Welfare and Institutions Code is repealed:

~~14132.957. (a) (1) It is the intent of the Legislature to adopt measures that will assist individuals who are living in the community to remain within their home environment and avoid unnecessary emergency room usage and hospital and nursing facility admissions due to those individuals not taking medications as prescribed.~~

(2) The Legislature finds and declares that certain seniors, persons with disabilities, and other Medi-Cal recipients are at high risk of not taking medications as prescribed and that measures to assist them in taking prescribed medications will advance the state's objectives to save lives, reduce health care costs, and assist individuals to continue living independently in their homes.

(3) The Legislature has determined that the achievement of these objectives will result in a net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting costs for implementing and administrating the pilot project.

(4) The Legislature therefore authorizes the establishment of the Home and Community Based Medication Dispensing Machine Pilot Project for utilization of an automated medication dispensing machine with associated monitoring and telephonic reporting services to assist Medi-Cal recipients with taking prescribed medications. All Medi-Cal recipients who participate in the pilot project shall do so voluntarily and shall be selected using criteria that demonstrates their susceptibility to not taking their medications as prescribed without monitoring or assistance.

(b) On and after the effective date of this section, the department, in consultation with the State Department of Social Services, shall begin implementation of the pilot project described in subdivision (a) and shall do all of the following:

(1) Establish criteria to identify at-risk Medi-Cal recipients who demonstrate susceptibility to not taking medications as prescribed.

These criteria shall be based on Medi-Cal, In-Home Supportive Services program and Medicare data and may include factors such as age, disability, multiple prescribed medications, and experience with or a high risk of experience with, numerous emergency department visits or hospital or nursing facility admissions within a specified time period as a result of not taking medications as prescribed.

(2) Identify an at-risk portion of Medi-Cal recipients of a sufficient number to achieve the intended savings. Recipients identified for this pilot project shall be limited to individuals who obtain Medi-Cal benefits through fee for service, who are not required to be enrolled on a mandatory basis in a Medi-Cal managed care health plan, and who are able to manage the medication dispensing machine independently or with the assistance of a family member or care provider and have a home environment capable of supporting the machine and associated telephonic reporting service that includes an active telephone line.

(3) To the extent necessary, the department shall do all of the following:

(A) Select and procure the automated medication dispensing machines, including costs for installation in a participant's home, as well as monitoring and repair services associated with operation of the machines.

(B) Provide an in-home, automated medication dispensing machine with telephonic reporting service for monitoring and assisting with taking medication, including installation, maintenance, alerts, training, and supplies at no cost to the recipient.

(4) Seek federal funding from the Centers for Medicare and Medicaid Services Innovation Center for the cost of the demonstration and other expenses, and to receive Medicare shared savings realized from the pilot project.

(5) Assess the potential for federal financial participation for these machines and any other expenses associated with this pilot project as well as receipt of federal

reimbursement for savings accrued to the Medicare program. If the department determines that federal financial participation is available under Title XI or XIX of the federal Social Security Act, the department shall seek a waiver or other federal approval, or submit a Medicaid State Plan amendment to implement the pilot project.

(c) (1) The department shall provide quarterly reports, beginning October 1, 2011, to the Department of Finance and the appropriate fiscal and policy committees of the Legislature, describing the number of recipients participating in the pilot project, the number of medication dispensing machines in use, costs of implementing and administering the pilot project, and any available data regarding medical and pharmacy utilization.

(2) The department shall also conduct an evaluation of the pilot project, including effects on service utilization, spending, outcomes, projected savings to the Medi-Cal program and the federal Medicare program, recommendations for improving the pilot project and maximizing savings to the state, and identification of other means of General Fund savings related to improving quality and cost-effectiveness of care, and shall report the evaluation to the appropriate policy and fiscal committees of the Legislature by December 31, 2013.

(3) (A) If the Department of Finance determines that the quarterly reports do not demonstrate the ability of the pilot project to achieve at least the estimated net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative costs, the Director of Finance shall notify the Chair of the Senate Committee on Budget and Fiscal Review and the Chair of the Assembly Committee on Budget of this determination, in writing, by April 10, 2012. Within 10 days following this notification, the Department of Finance shall convene a meeting with legislative staff to review the estimates related to its determination.

(B) Subsequent to the meeting pursuant to subparagraph (A), the Department of Finance shall request that the Legislature enact legislation on or before July 1, 2012, to either modify the pilot project, if necessary, or provide alternative options to achieve the balance of the net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative costs, or both.

(d) (1) Notwithstanding any other provision of law, if the Department of Finance determines after July 1, 2012, that the actions pursuant to subdivisions (b) and (c) will fail to achieve the net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative costs, the Department of Finance shall notify the State Department of Social Services and the department, and the State Department of Social Services, in consultation with the department, shall implement a reduction in authorized hours for in-home supportive services recipients beginning October 1, 2012, in accordance with Section 12301.03, to achieve a net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative costs of the pilot project and after taking into account any savings achieved pursuant to subdivisions (b) and (c).

(2) No earlier than 30 days after submission of the evaluation required by paragraph (2) of subdivision (c), the Department of Finance may adjust the amount of the reduction to meet net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund after fully offsetting implementation and administrative costs and after

~~taking into account any savings achieved pursuant to subdivisions (b) and (c). The calculations shall be based on updated data contained in the evaluation.~~

~~(e) For the purpose of implementing this section, the director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, or utilize existing provider enrollment or payment mechanisms. Any contract, contract amendment, or change order entered into for the purpose of implementing this section shall be exempt from Chapter 5.6 (commencing with Section 11545) of Part 1 of Division 3 of Title 2 of the Government Code, the Public Contract Code, and any associated policies, procedures, or regulations under these provisions, and shall be exempt from review or approval by any division of the Department of General Services and the California Technology Agency.~~

~~(f) 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 this section through all-county letters, provider bulletins, or similar instructions, without taking regulatory action.~~

~~(g) (1) Notwithstanding paragraph (2) of subdivision (c), the department may terminate operation of the pilot project if and to the extent that any of the following events occurs:~~

~~(A) Funding to implement and administer the pilot project is not appropriated in the 2012-13 fiscal year or annually thereafter.~~

~~(B) The Director of Finance notifies the Legislature that the pilot project is not projected to achieve a net annual savings or results in an overall increased cost.~~

~~(C) The pilot project conflicts with one or more provisions of state or federal law necessary to implement the pilot project.~~

~~(D) The department is unable to obtain from the Medicare program the data necessary to implement this pilot project, and the high-risk Medi-Cal only population is insufficient to conduct the pilot project.~~

~~(E) The department receives substantiated reports of adverse clinical outcomes indicating that continuing the pilot project poses unacceptable health risks to participants.~~

~~(2) Termination of the pilot project pursuant to paragraph (1) does not provide the department or the State Department of Social Services with authority to implement a reduction in authorized hours pursuant to Section 12301.03. Any reduction in authorized hours pursuant to Section 12301.03 shall comply with the requirements of subdivision (d).~~

~~(3) The department shall notify the appropriate fiscal and policy committees of the Legislature 30 days prior to terminating the pilot project.~~

SEC 8. Section 12301.03 of the Welfare and Institutions Code is repealed:

~~(a) (1) The Legislature finds and declares as follows:~~

~~(A) Authorized hours under the In-Home Supportive Services program were reduced in the 1992-93 fiscal year, and included a supplemental assessment process that was intended to ensure that recipients remained safely in their homes.~~

~~(B) The reduction in authorized hours as provided for in Chapter 8of the Statutes of 2011 includes a supplemental assessment process that is similarly intended to ensure that recipients remain safely in their homes.~~

~~(2) Notwithstanding any other provision of law, if the Department of Finance determines that a reduction in authorized hours of service is necessary, pursuant to subdivision (d) of Section 14132.957, the department shall implement a reduction in authorized hours of service to each in-home supportive services recipient as specified in this section, which shall be applied to the recipient's hours as authorized pursuant to his or her most recent assessment.~~

~~(3) The reduction required by this section shall not preclude any reassessment to which a recipient would otherwise be entitled. However, hours authorized pursuant to a reassessment shall be subject to the reduction required by this section.~~

~~(4) For those recipients who have a documented unmet need, excluding protective supervision, because of the limitations contained in Section 12303.4, this reduction shall be applied first to the unmet need before being applied to the authorized hours. If the recipient believes he or she will be at serious risk of out-of-home placement as a consequence of the reduction, the recipient may apply for a restoration of the reduction of authorized service hours, pursuant to Section 12301.05.~~

~~(5) A recipient of services under this article may direct the manner in which the reduction of hours is applied to the recipient's previously authorized services.~~

~~(6) The reduction in service hours made pursuant to paragraph (2)shall not apply to in-home supportive services recipients who also receive services under Section 9560, subdivision (t) of Section14132, and Section 14132.99.~~

~~(b) The department shall work with the counties to develop a process to allow for counties to preapprove IHSS Care Supplements described in Section 12301.05, to the extent that the process is permissible under federal law. The preapproval process shall be subject to the following conditions:~~

~~(1) The preapproval process shall rely on the criteria for assessing IHSS Supplemental Care applications, developed pursuant to Section 12301.05.~~

~~(2) Preapproval shall be granted only to individuals who would otherwise be granted a full restoration of their hours pursuant to Section 12301.05.~~

~~(3) With respect to existing recipients as of the effective date of this section, all efforts shall be made to ensure that counties complete the process on or before a specific date, as determined by the department, in consultation with counties in order to allow for the production, printing, and mailing of notices to be issued to remaining recipients who are not granted preapproval and who thereby are subject to the reduction pursuant to this section.~~

~~(4) The department shall work with counties to determine how to apply a preapproval process with respect to new applicants to the IHSS program who apply after the effective date of this section.~~

~~(c) The notice of action informing each recipient who is not preapproved for an IHSS Care Supplement pursuant to subdivision (b)shall be mailed at least 15 days prior to the reduction going into effect. The notice of action shall be understandable to the recipientand translated into all languages spoken by a substantial number of the public served by the In-Home Supportive Services program, in accordance with Section 7295.2 of the Government Code. The notice shall not contain any recipient financial or confidential identifying information other than the recipient's name, address, and Case Management Information and Payroll System (CMIPS) client identification number, and shall include, but not be limited to, all of the following information:~~

~~(1) The aggregate number of authorized hours before the reduction pursuant to paragraph (2) of subdivision (a) and the aggregate number of authorized hours after the reduction.~~

~~(2) That the recipient may direct the manner in which the reduction of authorized hours is applied to the recipient's previously authorized services.~~

~~(3) How all or part of the reduction may be restored, as set forth in Section 12301.05, if the recipient believes he or she will be at serious risk of out-of-home placement as a consequence of the reduction.~~

~~(d) The department shall inform providers of any reduction to recipient hours through a statement on provider timesheets, after consultation with counties.~~

~~(e) The IHSS Care Supplement application process described in Section 12301.05 shall be completed before a request for a state hearing is submitted. If the IHSS Care Supplement application is filed within 15 days of the notice of action required by subdivision(c), or before the effective date of the reduction, the recipient shall be eligible for aid paid pending. A revised notice of action shall be issued by the county following evaluation of the IHSS Care Supplement application.~~

~~(f) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section11340) of Part 1 of Division 3 of Title 2 of the Government Code),the department may implement and administer this section through all-county letters or similar instruction from the department until regulations are adopted. The department shall adopt emergency regulations implementing this section no later than October 1, 2013.The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.~~

~~(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.~~

~~(g) If the Director of Health Care Services determines that federal approval is necessary to implement this section, Section12301.05, or both, these sections shall be implemented only after any state plan amendments required pursuant to Section 14132.95 are approved.~~

~~(h) This section shall become operative on the first day of the first month following 90 days after the effective date of Chapter 8of the Statutes of 2011, or October 1, 2012, whichever is later.~~

SEC 9 Section 12301.05 of the Welfare and Institutions Code is repealed:

~~(a) Any aged, blind, or disabled individual who is eligible for services under this chapter who receives a notice of action indicating that his or her services will be reduced under subdivision (a) of Section 12301.03 but who believes he or she is at serious risk of out-~~

~~of-home placement unless all or part of the reduction is restored may submit an IHSS Care Supplement application. When a recipient submits an IHSS Care Supplement application within15 days of receiving the reduction notice or prior to the implementation of the reduction, the recipient's in-home supportive services shall continue at the level authorized by the most recent assessment, prior to any reduction, until the county finds that the recipient does or does not require restoration of any hours through the IHSS Care Supplement. If the recipient disagrees with the county's determination concerning the need for the IHSS Care Supplement, the recipient may request a hearing on that determination.~~

~~(b) The department shall develop an assessment tool, in consultation with stakeholders, to be used by the counties to determine if a recipient is at serious risk of out-of-home placement as a consequence of the reduction of services pursuant to section12301.03. The assessment tool shall be developed utilizing standard of care criteria for relevant out-of-home placements that serve individuals who are aged, blind, or who have disabilities and who would qualify for IHSS if living at home, including, but not limited to, criteria set forth in Chapter 7.0 of the Manual of Criteria for Medi-Cal Authorization published by the State Department of Health care Services, as amended April 15, 2004, and the IHSS uniform assessment guidelines.~~

~~(c) Counties shall give a high priority to prompt screening of persons specified in this section to determine their need for an IHSS Care Supplement.~~

~~(d) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section11340) of Part 1 of Division 3 of Title 2 of the Government Code),the department may implement and administer this section through all-county letters or similar instruction from the department until regulations are adopted. The department shall adopt emergency regulations implementing this section no later than October 1, 2013.~~

~~The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.~~

~~(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State, and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.~~

~~(e) This section shall become operative on the first day of the first month following 90 days after the effective date of Chapter 8of the Statutes of 2011, or October 1, 2012, whichever is later.~~

SEC. 10 This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that health care for Californians is improved at the earliest possible time, it is necessary for this act to go into immediate effect.