An act to amend Section 4011.11 of the Penal Code, and to amend Sections 14059.5, 14094.20, 14127.6, 14184.10, 14184.30, 14184.40, 14197.4, and 14301.1 of, to amend and repeal Sections 14132.275, 14132.276, 14132.277, 14182.16, 14182.17, 14182.18, 14186, 14186.1, 14186.2, 14186.3, and 14186.4 of, to add Article 5.51 (commencing with Section 14184.100) to Chapter 7 of Part 3 of Division 9 of, and to repeal Article 3.9 (commencing with Section 14127) of Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal.

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

SECTION 1. Section 4011.11 of the Penal Code is amended to read:

4011.11. (a) (1) ~~The~~ Through December 31, 2022, the board of supervisors in each county, in consultation with the county sheriff, may designate an entity or entities to assist county jail inmates with submitting an application for a health insurance affordability program consistent with federal requirements.

(2) The board of supervisors shall not designate the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates unless the county sheriff agrees to perform this function.

(3) If the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates, the designation shall be subject to approval by the jail administrator or ~~his or her~~ their designee.

(b) (1) The jail administrator, or ~~his or her~~ their designee, may coordinate with an entity designated pursuant to subdivision ~~(a).~~ (a), through December 31, 2022.

(2) Commencing January 1, 2023, the jail administrator, or their designee, shall coordinate with an entity designated pursuant to subdivision (h), as applicable.

(c) Consistent with federal law, a county jail inmate who is currently enrolled in the Medi-Cal program shall remain eligible for, and shall not be terminated from, the program due to ~~his or her detention~~ their incarceration unless required by federal law, ~~he or she becomes~~ they become otherwise ineligible, or the inmate's suspension of benefits has ended pursuant to Section 14011.10 of the Welfare and Institutions Code.

(d) Notwithstanding any other state law, and only to the extent federal law allows and federal financial participation is available, an entity designated pursuant to subdivision (a) or (h) is authorized to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services authorized by Section 14053.7 of the Welfare and Institutions Code. An entity designated pursuant to subdivision (a) or (h) shall not determine Medi-Cal eligibility or redetermine Medi-Cal eligibility, unless the entity is the county human services agency.

(e) The fact that an applicant is an inmate shall not, in and of itself, preclude a county human services agency from processing an application for the Medi-Cal program submitted to it by, or on behalf of, that inmate.

(f) For purposes of this section, "health insurance affordability program" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act.

(2) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act.

(3) A program that makes coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code available to qualified individuals.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the

Government Code with cost-sharing reductions established under Section 1402 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any subsequent amendments to that act.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the ~~department~~ State Department of Health Care Services may implement this ~~section~~ section, in whole or in part, by means of all-county letters or similar instructions, without taking any further regulatory action.

(h) (1) Notwithstanding any other law, commencing January 1, 2023, the board of supervisors in each county, in consultation with the county sheriff, shall designate an entity or entities to assist county jail inmates and juvenile inmates in county juvenile facilities with submitting an application for, or otherwise facilitating their enrollment in, a health insurance affordability program consistent with federal requirements.

(2) The board of supervisors shall not designate the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates and juvenile inmates unless the county sheriff agrees to perform this function.

(3) If the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates and juvenile inmates, the designation shall be subject to approval by the jail administrator or their designee.

(4) (A) No sooner than January 1, 2023, the State Department of Health Care Services, in consultation with counties, Medi-Cal managed care plans, and Medi-Cal Behavioral Health Delivery Systems, shall develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with Medi-Cal managed care plans and Medi-Cal Behavioral Health Delivery Systems to facilitate continued behavioral health treatment in the community for county jail inmates and juvenile inmates that were receiving behavioral health services prior to their release.

(B) Notwithstanding any other law, including, but not limited to, Sections 11812 and 11845.5 of the Health and Safety Code and Section 5328 of the Welfare and Institutions Code, the sharing of health information, records, and other data with and among counties, Medi-Cal managed care plans, Medi-Cal Behavioral Health Delivery Systems, and other authorized providers or plan entities shall be permitted to the extent the State Department of Health Care Services determines it necessary to implement this paragraph.

(C) For purposes of this paragraph, the following definitions shall apply:

(i) "Medi-Cal Behavioral Health Delivery System" shall have the same meaning as set forth in subdivision (d) of Section 14184.402 of the Welfare and Institutions Code.

(ii) "Medi-Cal managed care plan" shall have the same meaning as set forth in subdivision (m) of Section 14184.101 of the Welfare and Institutions Code.

SEC. 2. Section 14059.5 of the Welfare and Institutions Code is amended to read:

14059.5. (a) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

(b) (1) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

(2) The department and its contractors shall update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, and make specific this subdivision by means of all-county letters, plan letters, plan provider bulletins, manuals, plan contract amendments, or similar instructions until regulations are revised or adopted.

(4) By July 1, 2022, the department shall revise or adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. This paragraph shall not apply to Medi-Cal Behavioral Health Delivery Systems, as defined in subdivision (d) of Section 14184.402.

(c) This section shall not be construed to limit the application of subdivisions (a) and (b) of Section 51184 of Title 22 of the California Code of Regulations.

SEC. 3. Section 14094.20 of the Welfare and Institutions Code is amended to read:

14094.20. (a) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking regulatory action, shall implement, interpret, or make specific this article, Article 2.97 (commencing with Section 14093), Article 2.98 (commencing with Section 14094), and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, CCS numbered letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By ~~July 1, 2020,~~ January 1, 2022, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

SEC. 4. Section 14127.6 of the Welfare and Institutions Code is amended to read:

14127.6. (a) The Health Home Program shall be implemented only if and to the extent federal financial participation is available and the federal Centers for Medicare and Medicaid Services approves any state plan amendments and any necessary waivers sought pursuant to this article.

(b) (1) Except as provided in paragraph (2) and subdivision (c), this article shall be implemented through the 2020–21 state fiscal year only if no additional General Fund moneys are used to fund the administration and costs of services.

(2) Notwithstanding any other law, for the 2021–22 state fiscal year and thereafter as applicable, this article may be implemented using General Fund moneys upon appropriation by the Legislature.

(c) Notwithstanding subdivision (b), if the department projects, based on analysis of current and projected expenditures for health home services prior to, during, or after the first eight quarters of implementation, that this article can be implemented in a manner that does not or will not result in a net increase in ongoing General Fund costs for the Medi-Cal program, the department may use state funds to fund any Health Home Program costs.

(d) The department may use new funding in the form of enhanced federal financial participation for health home services that are currently provided to fund additional costs for new Health Home Program services.

(e) ~~The~~ Through the 2020–21 state fiscal year, the department shall seek to fund the creation, implementation, and administration of the program with funding other than state general funds.

(f) The department may revise or terminate the Health Home Program any time after the first eight quarters of implementation if the department finds that the program fails to result in reduced inpatient stays, hospital admission rates, and emergency department visits, or results in substantial General Fund expense without commensurate decreases in Medi-Cal costs among program participants.

(g) (1) Notwithstanding any law, the department shall cease to implement the Health Home Program on January 1, 2022, or the effective date reflected in any necessary federal approvals obtained by the department to implement the Enhanced Care Management benefit under the California Advancing and Innovating Medi-Cal initiative pursuant to Section 14184.205, whichever is later.

(2) The department shall conduct any necessary close-out activities associated with the Health Home Program including, but not limited to, the evaluation required pursuant to subdivision (a) of Section 14127.5.

(3) This article shall remain in effect only until January 1, 2023, and as of that date is repealed.

SEC. 5. Section 14132.275 of the Welfare and Institutions Code is amended to read:

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

(b) After federal approval is obtained, the department shall establish the demonstration project that enables dual eligible beneficiaries to receive a continuum of services that maximizes access to, and coordination of, benefits between the Medi-Cal and Medicare programs and access to the continuum of long-term services and supports

and behavioral health services, including mental health and substance use disorder treatment services. The purpose of the demonstration project is to integrate services authorized under the federal Medicaid program (Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)). The demonstration project may also include additional services as approved through a demonstration project or waiver, or a combination of those.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(*l*) (1) (A) Except for the exemptions provided for in this section and in Section 14132.277, the department shall enroll dual eligible beneficiaries into a demonstration site unless the beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled on or before June 1, 2013, in a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS or in any entity with a contract with the department pursuant to Chapter 8.75 (commencing with Section 14591).

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

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

(ii) In areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in all enrollment materials, enrollment assistance

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

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

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

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

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

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

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

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

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

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

(iii) The beneficiary is enrolled in a home- and community-based waiver that is a Medi-Cal benefit under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n et seq.), except for persons enrolled in Multipurpose Senior Services Program services or beneficiaries receiving services through a regional center who resides in the County of San Mateo.

(iv) The beneficiary is receiving services through a regional center or state developmental center. However, a beneficiary receiving services through a regional center who resides in the County of San Mateo, by making an affirmative choice to opt in, may voluntarily enroll in the demonstration project, upon receipt of all legal notifications required pursuant to this section and applicable federal requirements.

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

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

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

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

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

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

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

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

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

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

(6) The department shall not terminate contracts in a demonstration site with a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care

case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive beneficiaries or who have been diagnosed with AIDS and with any entity with a contract pursuant to Chapter 8.75 (commencing with Section 14591), except as provided in the contract or pursuant to state or federal law.

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

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

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

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

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

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

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

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

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

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

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

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

(p) The department shall enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's oversight and readiness review activities specified in this section. These activities may include providing consumer assistance to beneficiaries affected by this section and conducting financial audits, medical surveys, and a review of the adequacy of provider networks of the managed care health plans participating in this section. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of the Department of Managed Health Care and the department. The department shall not delegate its authority under this section as the single state Medicaid agency to the Department of Managed Health Care. Notwithstanding any other law, this subdivision shall be operative only through June 30, 2017.

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

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

(B) The department shall require health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is not in compliance with one or more of the measures set forth in this section, the health plan shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the health plan shall take to improve its performance based on the standard or standards with which the health plan is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14197.7. This subparagraph is not intended to limit Section 14197.7.

(C) The department shall publish the results of these measures, including by posting on the department's internet website, on a quarterly basis.

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

(s) (1) Notwithstanding any other law, the demonstration project described in this section shall remain operative only through December 31, 2022, subject to subdivision (f) of section 14184.102.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 6. Section 14132.276 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

(g) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(h) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 7. Section 14132.277 of the Welfare and Institutions Code is amended to read:

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

(1) “Alternate health care service plan” means a prepaid health plan that is a nonprofit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies, and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical

group in each specific geographic region in which it operates to provide services to enrollees.

(2) "Cal MediConnect plan" means a health plan or other qualified entity jointly selected by the state and CMS for participation in the demonstration project.

(3) "CMS" means the federal Centers for Medicare and Medicaid Services.

(4) "Coordinated Care Initiative county" means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, and any other county identified in Appendix 3 of the Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and the State of California, Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, inclusive of all amendments, as authorized by Section 14132.275.

(5) "D-SNP plan" means a Medicare Advantage Dual Special Needs Plan.

(6) "D-SNP contract" means a federal Medicare Improvements for Patients and Provider Act of 2008 (Public Law 110-275) compliant contract between the department and a D-SNP plan.

(7) "Demonstration project" means the demonstration project authorized by Section 14132.275.

(8) "Excluded beneficiaries" means those beneficiaries who are not eligible to participate in the demonstration project pursuant to subdivision (*l*) of Section 14132.275.

(9) "FIDE-SNP plan" means a Medicare Advantage Fully-Integrated Dual Eligible Special Needs Plan.

(10) "Non-Coordinated Care Initiative counties" means counties not participating in the demonstration project.

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

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(c) In Coordinated Care Initiative counties, Medicare Advantage plans and D-SNP plans may continue to enroll beneficiaries in 2014. In the 2014 calendar year, beneficiaries enrolled in a Medicare Advantage or D-SNP plan operating in a Coordinated Care Initiative county shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their Medicare Advantage or D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. If a beneficiary chooses to do so, that beneficiary may subsequently disenroll from the demonstration site and return to fee-for-service Medicare or to a D-SNP plan or Medicare Advantage plan.

(d) (1) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the department shall offer D-SNP contracts to D-SNP plans that were approved for the D-SNP plan's service areas as of January 1, 2013. In Coordinated Care Initiative counties, the department shall enter into D-SNP

contracts with D-SNP plans only for excluded beneficiaries and for those beneficiaries identified in paragraphs (2) and (5) of subdivision (g).

(2) For the 2022 contract year and the remainder of the demonstration project, in Coordinated Care Initiative counties, Medi-Cal managed care plans may transition beneficiaries enrolled in their affiliated non-D-SNP Medicare Advantage plans on or before January 1, 2021, into their affiliated D-SNP plan, if the D-SNP plan was approved for that service area as of January 1, 2013.

(e) For the 2015 calendar year and the remainder of the demonstration project, in non-Coordinated Care Initiative counties, the department ~~shall~~ may offer D-SNP contracts to D-SNP ~~plans.~~ plans, in accordance with Section 14184.208.

(f) The director may include in a D-SNP contract offered pursuant to subdivision (d) or (e) provisions requiring that the D-SNP plan do the following:

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(g) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the enrollment provisions of subdivision (*l*) of Section 14132.275 shall apply subject to the following:

(1) Beneficiaries enrolled in a FIDE-SNP plan or a Medicare Advantage plan, other than a D-SNP plan, shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275.

(2) If the D-SNP plan is not a Cal MediConnect plan, beneficiaries enrolled as of December 31, 2014, in a D-SNP plan shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. A dual eligible beneficiary who is enrolled as of December 31, 2014, in a D-SNP plan that is not a Cal MediConnect plan and who opts out of a demonstration site during the course of the demonstration project may choose to reenroll in that D-SNP plan.

(3) If the D-SNP is a Cal MediConnect plan, beneficiaries enrolled in a D-SNP plan who are eligible for the demonstration project shall be subject to the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275.

(4) For FIDE-SNP plans serving beneficiaries in Coordinated Care Initiative counties, the department shall require the following provisions:

(A) After December 31, 2014, enrollment in the County of Los Angeles shall not exceed 6,000 additional beneficiaries at any point during the term of the demonstration project. After December 31, 2014, enrollment in the combined Counties of Riverside and San Bernardino shall not exceed 1,500 additional beneficiaries at any point during the term of the demonstration project.This subparagraph shall be inoperative on July 1, 2021.

(B) Any necessary data or information requirements provided by the FIDE-SNP to ensure contract compliance.

(5) Beneficiaries enrolled in an alternate health care service plan (AHCSP) who become dually eligible for Medicare and Medicaid benefits while enrolled in that

AHCSP may elect to enroll in the AHCSP's D-SNP plan subject to the following requirements:

(A) The beneficiary was a member of the AHCSP immediately prior to becoming dually eligible for Medicare and Medicaid benefits.

(B) Upon mutual agreement between a Cal MediConnect Plan operated by a health authority or commission contracting with the department and the AHCSP, the AHCSP shall take full financial and programmatic responsibility for certain long-term supports and services of the D-SNP enrollee, including, but not limited to, certain long-term skilled nursing care, community-based adult services, multipurpose senior services program services, and other applicable Medi-Cal benefits offered in the demonstration project.

(6) Prior to assigning a beneficiary in a Medi-Cal managed care health plan pursuant to Section 14182.16, the department shall determine whether the beneficiary is already a member of the AHCSP. If so, the beneficiary shall be assigned to a Medi-Cal managed care health plan operated by a health authority or commission contracting with the department and subcontracting with the AHCSP.

(h) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(i) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 8. Section 14182.16 of the Welfare and Institutions Code is amended to read:

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

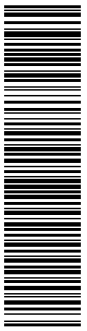
(b) For the purposes of this section and Section 14182.17, the following definitions shall apply:

(1) "Coordinated Care Initiative counties" means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

(e) At the director's sole discretion, in consultation with stakeholders, the department may determine and implement a phased-in enrollment approach that may include Medi-Cal beneficiary enrollment into managed care health plans immediately upon implementation of this section in a specific county, over a 12-month period, or

other phased approach. The phased-in enrollment shall commence no sooner than March 1, 2013, and not until all necessary federal approvals have been obtained.

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

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

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

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

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

(k) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591) may select a PACE plan if one is available in that county. Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the department or its enrollment contractor shall notify a dual eligible beneficiary who is subject to mandatory enrollment in a managed care plan and who is potentially eligible for PACE that ~~he or she~~ they may alternatively request to be assessed for eligibility for PACE, and, if eligible, may enroll in a PACE plan. The department or its enrollment contractor shall not enroll a dual eligible beneficiary who requests to be assessed for PACE in a managed care plan until the earlier of 60 days or the time that ~~he or she is~~ they are assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a managed care plan.

(*l*) Except for dual eligible beneficiaries participating in the demonstration project pursuant to Section 14132.275, persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary case management plan in operation on

that date, may select that primary care case management plan or a successor health care plan that is licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) to provide services within the same geographic area that the primary care case management plan served on January 1, 2010.

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

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

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

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

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

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

(p) The department shall, in coordination with and consistent with an interagency agreement with the Department of Managed Health Care, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans. Notwithstanding any other law, this subdivision shall remain operative only through June 30, 2017.

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

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

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

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

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

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

(w) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(x) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 9. Section 14182.17 of the Welfare and Institutions Code is amended to read:

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

(b) The department shall ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries residing in Coordinated Care Initiative counties who are either of the following:

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

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

(c) The department shall develop an enrollment process to be used in Coordinated Care Initiative counties to do the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) The materials shall be in a not more than sixth grade reading level and shall be available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate. For in-person enrollment assistance, disability accommodation shall be provided, when appropriate, through

means including, but not limited to, assistive listening systems, sign language interpreters, captioning, and written communication.

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

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

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

(I) The plan choices.

(II) Continuity of care provisions.

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

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

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

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

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

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

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

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

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

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

(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part

D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(H) Assign a primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions for partial-benefit

dual eligible beneficiaries who are receiving primary and specialty care through the Medi-Cal managed care health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Submit to the Legislature the following information:

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

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

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

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

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

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

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

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

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

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

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

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

(iii) Finalize rates and comprehensive contracts between the department and participating health plans to facilitate effective outreach, enroll network providers, and establish benefit packages. To the extent permitted by CMS, the plan rates and contract structure shall be provided to the appropriate fiscal and policy committees of the Legislature and posted on the department's internet website so that they are readily available to the public.

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

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

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

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

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

(ix) Develop continuity of care procedures.

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

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

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

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

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

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

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

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

(i) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any

determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(j) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 10. Section 14182.18 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

(B) Long-term services and supports costs for partial-benefit dual eligible beneficiaries, as defined in paragraph (7) of subdivision (b) of Section 14182.16, and non-dual-eligible beneficiaries who are enrolled in the managed care health plan if the plan's contract covers all Medi-Cal long-term services and supports.

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

(3) Risk corridors applied to costs of beneficiary services identified in subparagraph (B) of paragraph (1) shall only be in place for a period of 24 months starting with the first month in which mandatory coverage of all Medi-Cal long-term services and supports pursuant to Section 14186.2 has occurred.

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

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

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

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

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

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

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

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

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

(e) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(f) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 11. Section 14184.10 of the Welfare and Institutions Code is amended to read:

14184.10. For purposes of this article, the following definitions shall apply:

(a) "Demonstration project" means the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period from December 30, 2015, to December 31, 2020, inclusive, and any applicable extension period.

(b) "Demonstration term" means the entire period during which the demonstration project is in effect, as approved by the federal Centers for Medicare and Medicaid Services, including any applicable extension period.

(c) "Demonstration year" means the demonstration year as identified in the Special Terms and Conditions that corresponds to a specific period of time as set forth in paragraphs (1) to (6), inclusive. Individual programs under the demonstration project may be operated on program years that differ from the demonstration years identified in paragraphs (1) to (6), inclusive.

(1) Demonstration year 11 corresponds to the period of January 1, 2016, to June 30, 2016, inclusive.

(2) Demonstration year 12 corresponds to the period of July 1, 2016, to June 30, 2017, inclusive.

(3) Demonstration year 13 corresponds to the period of July 1, 2017, to June 30, 2018, inclusive.

(4) Demonstration year 14 corresponds to the period of July 1, 2018, to June 30, 2019, inclusive.

(5) Demonstration year 15 corresponds to the period of July 1, 2019, to June 30, 2020, inclusive.

(6) Demonstration year 16 corresponds to the period of July 1, 2020, to December 31, 2020, inclusive.

(d) "Dental Transformation Initiative" or "DTI" means the waiver program intended to improve oral health services for children, as authorized under the Special Terms and Conditions and described in Section 14184.70.

(e) "Designated state health program" shall have the same meaning as set forth in the Special Terms and Conditions.

(f) (1) "Designated public hospital" means any one of the following hospitals, and any ~~successor~~ successor, including any restructured, reorganized, or differently named hospital, which is operated by a county, a city and county, the University of California, or special hospital authority described in Chapter 5 (commencing with Section 101850) or Chapter 5.5 (commencing with Section 101852) of Part 4 of Division 101 of the Health and Safety Code, or any additional public hospital, to the extent identified as a "designated public hospital" in the Special Terms and Conditions. Unless otherwise provided for in law, in the Medi-Cal State Plan, or in the Special Terms and Conditions, all references in law to a designated public hospital as defined in subdivision (d) of Section 14166.1 shall be deemed to refer to a hospital described in this section effective as of January 1, 2016, except as provided in paragraph (2):

(A) UC Davis Medical Center.

(B) UC Irvine Medical Center.

(C) UC San Diego Medical Center.

(D) UC San Francisco Medical Center.

(E) UCLA Medical Center.

(F) Santa Monica/UCLA Medical Center, also known as the Santa Monica-UCLA Medical Center and Orthopaedic Hospital.

(G) LA County Health System Hospitals:

(i) LA County Harbor/UCLA Medical Center.

(ii) LA County Olive View UCLA Medical Center.

(iii) LA County Rancho Los Amigos National Rehabilitation Center.

(iv) LA County University of Southern California Medical Center.

(H) Alameda Health System Hospitals, including the following:

(i) Highland Hospital, including the Fairmont and John George Psychiatric facilities.

(ii) Alameda Hospital.

(iii) San Leandro Hospital.

(I) Arrowhead Regional Medical Center.

(J) Contra Costa Regional Medical Center.

(K) Kern Medical Center.

(L) Natividad Medical Center.

(M) Riverside University Health System-Medical Center.

(N) San Francisco General Hospital.

(O) San Joaquin General Hospital.

(P) San Mateo Medical Center.

(Q) Santa Clara Valley Medical Center.

(R) Ventura County Medical Center.

(2) For purposes of the following reimbursement methodologies, the hospitals identified in clauses (ii) and (iii) of subparagraph (H) of paragraph (1) shall be deemed to be a designated public hospital as of the following effective dates:

(A) For purposes of the fee-for-service payment methodologies established and implemented under Section 14166.4, the effective date shall be the date described in paragraph (3) of subdivision (a) of Section 14184.30.

(B) For purposes of Article 5.230 (commencing with Section 14169.50), the effective date shall be January 1, 2017.

(g) "Disproportionate share hospital provisions of the Medi-Cal State Plan" means those applicable provisions contained in Attachment 4.19-A of the California Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services, that implement the payment adjustment program for disproportionate share hospitals.

(h) "Federal disproportionate share hospital allotment" means the amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for a federal fiscal year.

(i) "Federal medical assistance percentage" means the federal medical assistance percentage applicable for federal financial participation purposes for medical services under the Medi-Cal State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United States Code.

(j) "Global Payment Program" or "GPP" means the payment program authorized under the demonstration project and described in Section 14184.40 that assists participating public health care systems that provide health care for the uninsured and that promotes the delivery of more cost-effective, higher-value health care services and activities.

(k) "Nondesignated public hospital" means a public hospital as that term is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(*l*) "Nonfederal share percentage" means the difference between 100 percent and the federal medical assistance percentage.

(m) "PRIME" means the Public Hospital Redesign and Incentives in Medi-Cal program authorized under the demonstration project and described in Section 14184.50.

(n) "Total computable disproportionate share hospital allotment" means the federal disproportionate share hospital allotment for a federal fiscal year, divided by the applicable federal medical assistance percentage with respect to that same federal fiscal year.

(o) "Special Terms and Conditions" means those terms and conditions issued by the federal Centers for Medicare and Medicaid Services, including all attachments to those terms and conditions and any subsequent amendments approved by the federal Centers for Medicare and Medicaid Services, that apply to the demonstration project.

(p) "Uninsured" means an individual for whom there is no source of third-party coverage for the health care services the individual receives, as determined pursuant to the Special Terms and Conditions.

(q) "Whole Person Care pilot program" means a local collaboration among local governmental agencies, Medi-Cal managed care plans, health care and behavioral

health providers, or other community organizations, as applicable, that are approved by the department to implement strategies to serve one or more identified target populations, pursuant to Section 14184.60 and the Special Terms and Conditions.

SEC. 12. Section 14184.30 of the Welfare and Institutions Code is amended to read:

14184.30. The following payment methodologies and requirements implemented pursuant to Article 5.2 (commencing with Section 14166) shall be applicable as set forth in this section.

(a) (1) (A) For purposes of Section 14166.4, the references to "project year" and "successor demonstration year" shall include references to the demonstration term, as defined under this article, and to any extensions of the prior federal Medicaid demonstration project entitled "California Bridge to Reform Demonstration (Waiver No. 11-W-00193/9)."

(B) For purposes of Section 14166.4, the references to "project year" and "successor demonstration year" shall include references to the CalAIM term, as defined in subdivision (b) of section 14184.101, and to any extensions of the demonstration project pursuant to this article.

(2) The fee-for-service payment methodologies established and implemented under Section 14166.4 shall continue to apply with respect to designated public hospitals approved under the Medi-Cal State Plan.

(3) For the hospitals identified in clauses (ii) and (iii) of subparagraph (H) of paragraph (1) of subdivision (f) of Section 14184.10, the department shall seek any necessary federal approvals to apply the fee-for-service payment methodologies established and implemented under Section 14166.4 to these identified hospitals effective no earlier than the 2016–17 state fiscal year. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized. Prior to the effective date of any necessary federal approval obtained pursuant to this paragraph, these identified hospitals shall continue to be considered nondesignated public hospitals for purposes of the fee-for-service methodology authorized pursuant to Section 14105.28 and the applicable provisions of the Medi-Cal State Plan.

(4) The department shall continue to make reimbursement available to qualifying hospitals that meet the eligibility requirements for participation in the supplemental reimbursement program for hospital facility construction, renovation, or replacement pursuant to Section 14085.5 and the applicable provisions of the Medi-Cal State Plan. The department shall continue to make inpatient hospital payments for services that were historically excluded from a hospital's contract under the Selective Provider Contracting Program established under Article 2.6 (commencing with Section 14081) in accordance with the applicable provisions of the Medi-Cal State Plan. These payments shall not duplicate or supplant any other payments made under this article.

(b) During the 2015–16 state fiscal year, and subsequent state fiscal years that commence during the demonstration ~~term,~~ term or the CalAIM term, payment adjustments to disproportionate share hospitals shall not be made pursuant to Section 14105.98, except as otherwise provided in this ~~article.~~ article or Article 5.51 (commencing with Section 14184.100). Payment adjustments to disproportionate share hospitals shall be made solely in accordance with this ~~article.~~ article or Article 5.51 (commencing with Section 14184.100).

(1) Except as otherwise provided in this ~~article,~~ article or Article 5.51(commencing with Section 14184.100), the department shall continue to make all eligibility determinations and perform all payment adjustment amount computations under the disproportionate share hospital payment adjustment program pursuant to Section 14105.98 and pursuant to the disproportionate share hospital provisions of the Medi-Cal State Plan. For purposes of these determinations and computations, which include those made pursuant to Sections 14166.11 and 14166.16, all of the following shall apply:

(A) The federal Medicaid DSH reductions pursuant to Section 1396r-4(f)(7) of Title 42 of the United States Code shall be reflected as appropriate, including, but not limited to, the calculations set forth in subparagraph (B) of paragraph (2) of subdivision (am) of Section 14105.98.

(B) Services that were rendered under the Low Income Health Program authorized pursuant to Part 3.6 (commencing with Section 15909) shall be included.

(2) (A) Notwithstanding Section 14105.98, the federal disproportionate share hospital allotment specified for California under Section 1396r-4(f) of Title 42 of the United States Code for each of federal fiscal years 2016 to 2021, inclusive, shall be aligned with the state fiscal year in which the applicable federal fiscal year commences, and shall be distributed solely for the following purposes:

(i) As disproportionate share hospital payments under the methodology set forth in applicable disproportionate share hospital provisions of the Medi-Cal State Plan, which, to the extent permitted under federal law and the Special Terms and ~~Conditions,~~ Conditions, or the CalAIM Terms and Conditions, shall be limited to the following hospitals:

(I) Eligible hospitals, as determined pursuant to Section 14105.98 for each state fiscal year in which the particular federal fiscal year commences, that meet the definition of a public hospital, as specified in paragraph (25) of subdivision (a) of Section 14105.98, and that are not participating as GPP systems under the Global Payment Program.

(II) Hospitals that are licensed to the University of California, which meet the requirements set forth in Section 1396r-4(d) of Title 42 of the United States Code.

(ii) As a funding component for payments under the Global Payment Program, as described in subparagraph (A) of paragraph (1) of subdivision (c) of Section ~~14184.40~~ 14184.40, or paragraph (1) of subdivision (c) of Section 14184.300, and the Special Terms and ~~Conditions.~~ Conditions or the CalAIM Terms and Conditions.

(B) The distribution of the federal disproportionate share hospital allotment to hospitals described in this paragraph shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code.

(3) (A) During the 2015–16 state fiscal year and subsequent state fiscal years that commence during the demonstration ~~term,~~ term or the CalAIM term, a public entity shall not be obligated to make any intergovernmental transfer pursuant to Section 14163, and all transfer amount determinations for those state fiscal years shall be suspended. However, intergovernmental transfers shall be made with respect to the disproportionate share hospital payment adjustments made in accordance with clause (ii) of subparagraph (B) of paragraph (6), as applicable.

(B) During the 2015–16 state fiscal year and subsequent state fiscal years that commence during the demonstration ~~term,~~ term or the CalAIM term, transfer amounts from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund, as described in paragraph (2) of subdivision (d) of Section 14163, are hereby reduced to zero. Unless otherwise specified in this article or the applicable provisions of Article 5.2 (commencing with Section 14166), this subparagraph shall be disregarded for purposes of the calculations made under Section 14105.98 during the 2015–16 state fiscal year and subsequent state fiscal years that commence during the demonstration ~~term.~~ term or the CalAIM term.

(4) (A) During the state fiscal years for which the Global Payment Program under Section ~~14184.40~~ 14184.40, or Section 14184.300, is in effect, designated public hospitals that are participating GPP systems shall not be eligible to receive disproportionate share hospital payments pursuant to otherwise applicable disproportionate share hospital provisions of the Medi-Cal State Plan.

(B) Eligible hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are nondesignated public hospitals shall continue to receive disproportionate share hospital payment adjustments as set forth in Section 14166.16.

(C) Hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are licensed to the University of California shall receive disproportionate share hospital payments as follows:

(i) Subject to clause (iii), each hospital licensed to the University of California may draw and receive federal Medicaid funding from the applicable federal disproportionate share hospital allotment on the amount of certified public expenditures for the hospital's expenditures that are eligible for federal financial participation as reported in accordance with Section 14166.8 and the applicable disproportionate share hospital provisions of the Medi-Cal State Plan.

(ii) Subject to clause (iii) and to the extent the hospital meets the requirement in Section 1396r-4(b)(1)(A) of Title 42 of the United States Code regarding the Medicaid inpatient utilization rate or Section 1396r-4(b)(1)(B) of Title 42 of the United States Code regarding the low-income utilization rate, each hospital shall receive intergovernmental transfer-funded direct disproportionate share hospital payments as provided for under the applicable disproportionate share hospital provisions of the Medi-Cal State Plan. The total amount of these payments to the hospital, consisting of the federal and nonfederal components, shall in no case exceed that amount equal to 75 percent of the hospital's uncompensated Medi-Cal and uninsured costs of hospital services as reported in accordance with Section 14166.8.

(iii) Unless the provisions of subparagraph (D) apply, the aggregate amount of the federal disproportionate share hospital allotment with respect to payments for an applicable state fiscal year to hospitals licensed to the University of California shall be limited to an amount calculated as follows:

(I) The maximum amount of federal disproportionate share hospital allotment for the state fiscal year, less the amounts of federal disproportionate share hospital allotment associated with payments to nondesignated public hospitals under subparagraph (B) and other payments, if any, required to be made from the federal disproportionate share hospital allotment, shall be determined.

(II) For the 2015–16 state fiscal year, the amount determined in subclause (I) shall be multiplied by 26.296 percent, resulting in the maximum amount of the federal

disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(III) For the 2016–17 state fiscal year, the amount determined in subclause (I) shall be multiplied by 24.053 percent, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(IV) For the 2017–18 state fiscal year, the amount determined in subclause (I) shall be multiplied by 23.150 percent, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(V) For each of the 2018–19 and 2019–20 state fiscal years, the amount determined in subclause (I) shall be multiplied by 21.896 percent, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(VI) For the 2020–21 state fiscal year, and subsequent state fiscal years or portions thereof during the CalAIM Term, the amount determined in subclause (I) shall be multiplied by a percentage as determined by the department, in consultation with designated public hospitals and consistent with the applicable federal terms and conditions, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California. The percentage shall be communicated in writing to all of the designated public hospitals.

~~(VI)~~

(VII) To the extent the limitations set forth in this clause result in payment reductions for the applicable year, those reductions shall be applied pro rata, subject to clause (vii).

(iv) Each hospital licensed to the University of California shall receive quarterly interim payments of its disproportionate share hospital allocation during the applicable state fiscal year. The determinations set forth in clauses (i) to (iii), inclusive, shall be made on an interim basis prior to the start of each state fiscal year, except that the determinations for the 2015–16 state fiscal year shall be made as soon as practicable. The department shall use the same cost and statistical data used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4, and available payments and uncompensated and uninsured cost data, including data from the Medi-Cal paid claims file and the hospital's books and records, for the corresponding period, to the extent permitted under the Medi-Cal State Plan.

(v) No later than April 1 following the end of the relevant reporting period for the applicable state fiscal year, the department shall undertake an interim reconciliation of payments based on Medi-Cal, Medicare, and other cost, payment, discharge, and statistical data submitted by the hospital for the applicable state fiscal year, and shall adjust payments to the hospital accordingly.

(vi) Except as otherwise provided in this ~~article,~~ article or Article 5.51 (commencing with Section 14184.100), each hospital licensed to the University of

California shall receive disproportionate share hospital payments subject to final audits of all applicable Medi-Cal, Medicare, and other cost, payment, discharge, and statistical data submitted by the hospital for the applicable state fiscal year.

(vii) Prior to the interim and final distributions of payments pursuant to clauses (iv) to (vi), inclusive, the department shall consult with the University of California, and implement any adjustments to the payment distributions for the hospitals as requested by the University of California, so long as the aggregate net effect of the requested adjustments for the affected hospitals is zero.

(D) With respect to any state fiscal year commencing during the demonstration term or the CalAIM term for which the Global Payment Program pursuant to Section 14184.40 or 14184.300 is not in effect, designated public hospitals that are eligible hospitals as determined pursuant to Section 14105.98, and hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are licensed to the University of California, shall claim disproportionate share hospital payments in accordance with the applicable disproportionate share hospital provisions of the Medi-Cal State Plan. The allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment shall be made in accordance with the methodology set forth in Section 14166.61.

(5) For each applicable state fiscal year during the demonstration term or the CalAIM term, eligible hospitals, as determined pursuant to Section 14105.98, which are nonpublic hospitals, nonpublic-converted hospitals, and converted hospitals, as those terms are defined in paragraphs (26), (27), and (28), respectively, of subdivision (a) of Section 14105.98, shall continue to receive Medi-Cal disproportionate share hospital replacement payment adjustments pursuant to Section 14166.11 and other provisions of this article or Article 5.51 (commencing with Section 14184.100) and applicable provisions of the Medi-Cal State Plan. The payment adjustments so provided shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code. The provisions of subdivision (j) of Section 14166.11 shall continue to apply with respect to the 2015–16 state fiscal year and subsequent state fiscal years commencing during the demonstration term or the CalAIM term. Except as may otherwise be required by federal law, the federal share of these payments shall not be claimed from the federal disproportionate share hospital allotment.

(6) The nonfederal share of disproportionate share hospital payments and disproportionate share hospital replacement payment adjustments described in paragraphs (4) and (5) shall be derived from the following sources:

(A) With respect to the payments described in subparagraph (B) of paragraph (4) that are made to nondesignated public hospitals, the nonfederal share shall consist solely of state General Fund appropriations.

(B) With respect to the payments described in subparagraph (C) or (D), as applicable, of paragraph (4) that are made to designated public hospitals, the nonfederal share shall consist of both of the following:

(i) Certified public expenditures incurred by the hospitals for hospital expenditures eligible for federal financial participation as reported in accordance with Section 14166.8.

(ii) Intergovernmental transfer amounts for direct disproportionate share hospital payments provided for under subparagraph (C) or (D) of paragraph (4) and the

applicable disproportionate share hospital provisions of the Medi-Cal State Plan. A transfer amount shall be determined for each hospital that is eligible for these payments, equal to the nonfederal share of the payment amount established for the hospital. The transfer amount determined shall be paid by the hospital, or the public entity with which the hospital is affiliated, and deposited into the Medi-Cal Inpatient Payment Adjustment Fund established pursuant to subdivision (b) of Section 14163, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(C) With respect to the payments described in paragraph (5), the nonfederal share shall consist of state General Fund appropriations.

(7) The Demonstration Disproportionate Share Hospital Fund established in the State Treasury pursuant to subdivision (d) of Section 14166.9 shall be retained during the demonstration term and the CalAIM term. All federal funds received by the department with respect to the certified public expenditures claimed pursuant to subparagraph (C), and, as applicable in subparagraph (D), of paragraph (4) shall be transferred to the fund and disbursed to the eligible designated public hospitals pursuant to those applicable provisions. Notwithstanding Section 13340 of the Government Code, moneys deposited in the fund shall be continuously appropriated, without regard to fiscal year, to the department solely for the purposes specified in this ~~article.~~ article and Article 5.51 (commencing with Section 14184.100).

(c) (1) Disproportionate share hospital payment allocations under Sections 14166.3 and 14166.61, and safety net care pool payment allocations under Section 14166.71, that were paid to designated public hospitals with respect to the period July 1, 2015, through October 31, 2015, or for subsequent periods pursuant to Section 14166.253, shall be reconciled to amounts payable to the hospitals under this article as set forth in this subdivision.

(2) The disproportionate share hospital payments and safety net care pool payments described in paragraph (1) that were paid to a designated public hospital participating in a GPP system under Section 14184.40 shall be deemed to be interim payments under the Global Payment Program for GPP program year 2015–16, and will be reconciled to and offset against the interim payment amount due to the GPP system under subparagraph (B) of paragraph (4) of subdivision (d) of Section 14184.40, consistent with the Special Terms and Conditions.

(3) The disproportionate share hospital payments described in paragraph (1) that were paid to designated public hospitals licensed to the University of California shall be reconciled to and offset against the disproportionate share hospital payments payable to the hospitals under subparagraph (C) of paragraph (4) of subdivision (b) for the 2015–16 state fiscal year.

(4) The safety net care pool payments described in paragraph (1) that were paid to designated public hospitals licensed to the University of California shall be recouped and included as available funding under the Global Payment Program for the 2015–16 GPP program year described in subparagraph (B) of paragraph (1) of subdivision (c) of Section 14184.40.

(d) During the 2015–16 state fiscal year, and subsequent state fiscal years that commence during the demonstration term or the CalAIM term, costs shall continue to be determined and reported for designated public hospitals in accordance with Sections 14166.8 and 14166.24, except as follows:

(1) (A) The provisions of subdivision (c) of Section 14166.8 shall not apply.

(B) Notwithstanding subparagraph (A), the department may require the reporting of any data the department deems necessary to satisfy reporting requirements pursuant to the Special Terms and Conditions or the CalAIM Terms and Conditions.

(2) The provisions of Sections 14166.221 and 15916 shall not apply with respect to any costs reported for the demonstration term or the CalAIM term pursuant to Section 14166.8.

(e) (1) Notwithstanding subdivision (h) of Section 14166.61 and subdivision (c) of Section 14166.71, the disproportionate share hospital allocation and safety net care pool payment determinations and payments for the 2013–14 and 2014–15 state fiscal years shall be deemed final as of the April 30 that is 22 months following the close of the respective state fiscal year, to the extent permitted under federal law and subject to recoupment pursuant to subdivision (f) if it is later determined that federal financial participation is not available for any portion of the applicable payments.

(2) The determinations and payments shall be finalized using the best available data, including unaudited data, and reasonable current estimates and projections submitted by the designated public hospitals. The department shall accept all appropriate revisions to the data, estimates, and projections previously submitted, including revised cost reports, for purposes of this subdivision, to the extent these revisions are submitted in a timely manner as determined by the department.

(f) Upon receipt of a notice of disallowance or deferral from the federal government related to the certified public expenditures or intergovernmental transfers of a designated public hospital or governmental entity with which it is affiliated for disproportionate share hospital payments or safety net care pool payments claimed and distributed pursuant to Section 14166.61, 14166.71, or 15916 for the 2013–14 or 2014–15 state fiscal year, the department shall promptly notify the designated public hospitals and proceed as follows:

(1) To the extent there are additional certified public expenditures for the applicable state fiscal year for which federal funds have not been received, but for which federal funds could have been received had additional federal funds been available, including any subsequently allowable expenditures for designated state health programs, the department shall first respond to the deferral or disallowance by substituting the additional certified public expenditures or allowable expenditures for those deferred or disallowed, consistent with the claiming optimization priorities set forth in Section 14166.9, in consultation with the designated public hospitals, but only to the extent that any necessary federal approvals are obtained or these actions are otherwise permitted by federal law.

(2) The department shall consult with the designated public hospitals and proceed in accordance with paragraphs (2) and (3) of subdivision (d) of Section 14166.24.

(3) If the department elects to appeal pursuant to paragraph (3) of subdivision (d) of Section 14166.24, the department shall not implement any recoupment of payments from the affected designated public hospitals, until a final disposition has been made regarding the deferral or disallowance, including the conclusion of applicable administrative and judicial review, if any.

(4) (A) Upon final disposition of the federal deferral or disallowance, the department shall determine the resulting aggregate repayment amount of federal funds for each affected state fiscal year.

(B) The department shall determine the ratio of the aggregate repayment amount to the total amount of the federal share of payments finalized and distributed pursuant to Sections 14166.61 and 14166.71 and subdivision (e) for each affected state fiscal year, expressed as a percentage.

(5) Notwithstanding paragraph (1) of subdivision (d) of Section 14166.24, the responsibility for repayment of the federal portion of any deferral of disallowance for each affected year shall be determined as follows:

(A) The provisions of subdivision (g) of Section 15916 shall be applied to determine the department's repayment responsibility amount with respect to any deferral or disallowance related to safety net care pool payments, which shall be in addition to amounts determined under subparagraph (E).

(B) Using the most recent data for the applicable fiscal year, and reflecting modifications to the applicable initial DSH claiming ability and initial SNCP claiming ability for individual hospitals resulting from the deferral or disallowance, the department shall perform the calculations and determinations for each designated public hospital as set forth in Sections 14166.61 and 14166.71. For this purpose, the calculations and determinations shall assume no reduction in the available federal disproportionate share hospital allotment or in the amount of available safety net care pool payments as a result of the deferral or disallowance.

(C) For each designated public hospital, the revised determinations of disproportionate share hospital and safety net care pool payment amounts under subparagraph (B) shall be combined and compared to the combined disproportionate share hospital and safety net care pool payment amounts determined and received by the hospital pursuant to subdivision (e). For this purpose and purposes of subparagraph (D), the applicable data for designated public hospitals described in subparagraph (G) of paragraph (1) of subdivision (f) of Section 14184.10 shall be combined, and the applicable data for designated public hospitals described in subparagraphs (E) and (F) of paragraph (1) of subdivision (f) of Section 14184.10 shall be combined.

(D) (i) Subject to subparagraph (E), the repayment of the federal portion of the deferral of disallowance, less the department's responsibility amount for safety net care pool payments, if any, determined in subparagraph (A), shall be first allocated among each of those designated public hospitals for which the combined revised disproportionate share hospital and safety net care pool payments as determined in subparagraph (B) are less than the combined disproportionate share hospital and safety net care pool payment amounts determined and received pursuant to subdivision (e). Repayment shall be allocated under this initial stage among these hospitals pro rata on the basis of each hospital's relative reduction as reflected in the revised calculations performed under subparagraph (B), but in no case shall the allocation to a hospital exceed the limit in clause (iii). Repayment amounts that are not allocated due to this limitation shall be allocated pursuant to clause (ii).

(ii) Subject to subparagraph (E), any repayment amounts that were unallocated to hospitals due to the limitation in clause (iii) shall be allocated in a second stage among each of the remaining designated public hospitals that has not reached its applicable repayment limit, including the hospitals that were not subject to the allocations under clause (i), based pro rata on the amounts determined and received by the hospital pursuant to subdivision (e), except that no repayment amount for a hospital shall exceed the limitation under clause (iii). The pro rata allocation process

will be repeated in subsequent stages with respect to any repayment amounts that cannot be allocated in a prior stage to hospitals due to the limitation under clause (iii), until the entire federal repayment amount has been allocated among the hospitals.

(iii) The repayment amount allocated to a designated public hospital pursuant to this subparagraph shall not exceed an amount equal to the percentage of the combined payments determined and received by the hospital pursuant to subdivision (e) that is twice the percentage computed in subparagraph (B) of paragraph (4).

(E) Notwithstanding any other law, if the affiliated governmental entity for the designated public hospital is a county subject to the provisions of Article 12 (commencing with Section 17612.1) of Chapter 6 of Part 5, the department, in consultation with the affected designated public hospital, and the Department of Finance, shall determine how to account for whether any repayment amount determined for the designated public hospital pursuant to subparagraph (D) for the 2013–14 and 2014–15 state fiscal years would otherwise have affected, if at all, the applicable county's redirection obligation for the applicable state fiscal year pursuant to paragraphs (4) and (5) of subdivision (a) of Section 17612.3 and shall determine what adjustments, if any, are necessary to either the repayment amount or the applicable county's redirection obligation. For purposes of this subparagraph, the provisions of subdivision (f) of Section 17612.2 and paragraph (7) of subdivision (e) of Section 101853 of the Health and Safety Code shall apply.

(g) The provisions of Article 5.2 (commencing with Section 14166) shall remain in effect until all payments authorized pursuant to that article have been paid, finalized, and settled, and to the extent its provisions are retained for purposes of this ~~article.~~ article or Article 5.51 (commencing with Section 14184.100).

(h) For purposes of this article, commencing January 1, 2021, and thereafter, any references to "Designated Public Hospital," "CalAIM term," or "CalAIM Terms and Conditions" shall have the same meanings as set forth in Section 14184.101.

SEC. 13. Section 14184.40 of the Welfare and Institutions Code is amended to read:

14184.40. (a) (1) The department shall implement the Global Payment Program authorized under the demonstration project to support participating public health care systems that provide health care services for the uninsured. Under the Global Payment Program, GPP systems receive global payments based on the health care they provide to the uninsured, in lieu of traditional disproportionate share hospital payments and safety net care pool payments previously made available pursuant to Article 5.2 (commencing with Section 14166).

(2) The Global Payment Program is intended to streamline funding sources for care for California's remaining uninsured population, creating a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services. The Global Payment Program supports GPP systems for their key role providing and promoting effective, higher value services to California's remaining uninsured. Promoting more cost-effective and higher value care means that the payment structure rewards the provision of care in more appropriate venues for patients, and will support structural changes to the care delivery system that will improve the options for treating both Medi-Cal and uninsured patients.

(3) Under the Global Payment Program, GPP systems will receive Global Payment Program payments calculated using an innovative value-based point

methodology that incorporates measures of value for the patient in conjunction with the recognition of costs. To receive the full amount of Global Payment Program payments, a GPP system shall provide a threshold level of services, as measured in the point methodology described in paragraph (2) of subdivision (c), and based on the GPP system's historical volume, cost, and mix of services. This payment methodology is intended to support GPP systems that continue to provide services to the uninsured, while incentivizing the GPP systems to shift the overall delivery of services for the uninsured to provide more cost-effective, higher value care.

(4) The department shall implement and oversee the operation of the Global Payment Program in accordance with the Special Terms and Conditions and the requirements of this section, to maximize the amount of federal financial participation available to participating GPP systems.

(b) For purposes of this article, the following definitions apply:

(1) "GPP system" means a public health care system that consists of a designated public hospital, as defined in subdivision (f) of Section 14184.10 but excluding the hospitals operated by the University of California, and its affiliated and contracted providers. Multiple designated public hospitals operated by a single legal entity may belong to the same GPP system, to the extent set forth in the Special Terms and Conditions.

(2) "GPP program year" means a state fiscal year beginning on July 1 and ending on June 30 during which the Global Payment Program is authorized under the demonstration project, beginning with state fiscal year 2015–16, and, as applicable, each state fiscal year thereafter through 2019–20, and any years or partial years during which the Global Payment Program is authorized under an extension or successor to the demonstration project.

(c) (1) For each GPP program year, the department shall determine the Global Payment Program's aggregate annual limit, which is the maximum amount of funding available under the demonstration project for the Global Payment Program and which is the sum of the components described in subparagraphs (A) and (B). To the extent feasible, the aggregate annual limit shall be determined and made available by the department before the implementation of a GPP program year, and shall be updated and adjusted as necessary to reflect changes or adjustments to the amount of funding available for the Global Payment Program.

(A) A portion of the federal disproportionate share allotment specified for California under Section 1396r-4(f) of Title 42 of the United States Code shall be included as a component of the aggregate annual limit for each GPP program year. The amount of this portion shall equal the state's total computable disproportionate share allotment reduced by the maximum amount of funding projected for payments pursuant to subparagraphs (B) and (C) of paragraph (4) of subdivision (b) of Section 14184.30 to disproportionate share hospitals that are not participating in the Global Payment Program. For purposes of this determination, the federal disproportionate share allotment shall be aligned with the GPP program year in which the applicable federal fiscal year commences.

(B) The aggregate annual limit shall also include the amount authorized under the demonstration project for the uncompensated care component of the Global Payment Program for the applicable GPP program year, as determined pursuant to the Special Terms and Conditions.

(2) The department shall develop a methodology for valuing health care services and activities provided to the uninsured that achieves the goals of the Global Payment Program, including those values set forth in subdivision (a) and as expressed in the Special Terms and Conditions. The points assigned to a particular service or activity shall be the same across all GPP systems. Points for specific services or activities may be increased or decreased over time as the Global Payment Program progresses, to incentivize appropriate changes in the mix of services provided to the uninsured. To the extent necessary, the department shall obtain federal approval for the methodology and any applicable changes to the methodology.

(3) For each GPP system, the department shall perform a baseline analysis of the GPP system's historical volume, cost, and mix of services to the uninsured to establish an annual threshold for purposes of the Global Payment Program. The annual threshold shall be measured in points established through the methodology developed pursuant to paragraph (2) and as set forth in the Special Terms and Conditions.

(4) The department shall determine a pro rata allocation percentage for each GPP system by dividing the GPP system's annual threshold determined in paragraph (3) by the sum of all GPP systems' thresholds.

(5) For each GPP system, the department shall determine an annual budget the GPP system will receive if it achieves its threshold. A GPP system's annual budget shall equal the allocation percentage determined in paragraph (4) for the GPP system, multiplied by the Global Payment Program's aggregate annual limit determined in paragraph (1).

(6) In the event of a change in the aggregate annual limit, the department shall adjust and recalculate each GPP system's annual threshold ~~and~~ or the annual budget in proportion to changes in the aggregate annual limit calculated in paragraph (1) in accordance with the Special Terms and Conditions.

(d) The amount of Global Payment Program funding payable to a GPP system for a GPP program year shall be calculated as follows, subject to the Special Terms and Conditions:

(1) The full amount of a GPP system's annual budget shall be payable to the GPP system if the services it provided to the uninsured during the GPP program year, as measured and scored using the point methodology described under paragraph (2) of subdivision (c), meets or exceeds its threshold for a given year. For GPP systems that do not achieve their threshold, the amount payable to the GPP system shall equal its annual budget reduced by the proportion by which it fell short of its threshold.

(2) The department shall develop a methodology to redistribute unearned Global Payment Program funds for a given GPP program year to those GPP systems that exceeded their respective threshold for that same year. To the extent sufficient funds are available for all qualifying GPP systems, the GPP system's redistributed amount shall equal the GPP system's annual budget multiplied by the percentage by which the GPP system exceeded its threshold, and any remaining amounts of unearned funds will remain undistributed. If sufficient funds are unavailable to make all these payments to qualifying GPP systems, the amounts of these additional payments will be reduced for all qualifying GPP systems by the same proportion, so that the full amount of unearned Global Payment Program funds are redistributed. Redistributed payment amounts calculated pursuant to this paragraph shall be added to the amounts payable to a GPP system calculated pursuant to paragraph (1).

(3) The department shall specify a reporting schedule for participating GPP systems to submit an interim yearend report and a final reconciliation report for each GPP program year. The interim yearend report and the final reconciliation report shall identify the services the GPP system provided to the uninsured during the GPP program year, the associated point calculation, and the amount of payments earned by the GPP system before any redistribution. The method and format of the reporting shall be established by the department, consistent with the approved Special Terms and Conditions.

(4) Payments shall be made in the manner and within the timeframes as follows, except if one or more GPP systems fail to provide the intergovernmental transfer amount determined pursuant to subdivision (g) by the date specified in this paragraph, the timeframe for the associated payments shall be extended to the extent necessary to allow the department to timely process the payments. In no event, however, shall payment be delayed beyond 21 days after all the necessary intergovernmental transfers have been made.

(A) Except as provided in subparagraph (B), for each of the first three quarters of a GPP program year the department shall notify GPP systems of their payment amounts and intergovernmental transfer amounts and make a quarterly interim payment equal to 25 percent of each GPP system's annual global budget to the GPP system.

(i) For quarters ending September 30, the payment amount and intergovernmental transfer amount notice shall be sent by September 15, intergovernmental transfers shall be due by September 22, and payments shall be made by October 15.

(ii) For quarters ending December 31, the payment amount and intergovernmental transfer amount notice shall be sent by December 15, intergovernmental transfers shall be due by December 22, and payments shall be made by January 15.

(iii) For quarters ending March 31, the payment amount and intergovernmental transfer amount notice shall be sent by March 15, intergovernmental transfers shall be due by March 22, and payments shall be made by April 15.

(B) For the 2015–16 GPP program year, the department shall make the quarterly interim payments described in subdivision (a) in a single interim payment for the first three quarters as soon as practicable following approval of the Global Payment Program protocols as part of the Special Terms and Conditions and receipt of the associated intergovernmental transfers. The amount of this interim payment that is otherwise payable to a GPP system shall be reduced by the payments described in paragraph (2) of subdivision (c) of Section 14184.30 that were received by a designated public hospital affiliated with the GPP system.

(C) By September 15 following the end of each GPP program year, the department shall determine and notify each GPP system of the amount the GPP system earned for the GPP program year pursuant to paragraph (1) based on its interim yearend report, the amount of additional interim payments necessary to bring the GPP system's aggregate interim payments for the GPP program year to that amount, and the transfer amounts calculated pursuant to subdivision (g). If the GPP system has earned less than 75 percent of its annual budget, no additional interim payment will be made for the GPP program year. Intergovernmental transfer amounts shall be due by September 22 following the end of the GPP program year, and interim payments shall be made by October 15 following the end of each GPP program year. All interim payments shall be subject to reconciliation after the submission of the final reconciliation report.

(D) By June 30 following the end of each GPP program year, the department shall review the final reconciliation reports and determine and notify each GPP system of the final amounts earned by the GPP system for the GPP program year pursuant to paragraph (1), as well as the redistribution amounts, if any, pursuant to paragraph (2), the amount of the payment adjustments or recoupments necessary to reconcile interim payments to those amounts, and the transfer amount pursuant to subdivision (g). Intergovernmental transfer amounts shall be due by July 14 following the notification, and final reconciliation payments for the GPP program year shall be made no later than August 15 following this notification.

(e) The Global Payment Program provides a source of funding for GPP systems to support their ability to make health care activities and services available to the uninsured, and shall not be construed to constitute or offer health care coverage for individuals receiving services. Global Payment Program payments are not paid on behalf of specific individuals, and participating GPP systems may determine the scope, type, and extent to which services are available, to the extent consistent with the Special Terms and Conditions. The operation of the Global Payment Program shall not be construed to decrease, expand, or otherwise alter the scope of a county's obligations to the medically indigent pursuant to Part 5 (commencing with Section 17000) of Division 9.

(f) The nonfederal share of any payments under the Global Payment Program shall consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or affiliated governmental agencies or entities, in accordance with this ~~section.~~ section or Section 14184.300.

(1) The Global Payment Program Special Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys deposited in the Global Payment Program Special Fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this ~~section.~~ section or Section 14184.300. All funds derived pursuant to this section or Section 14184.300 shall be deposited in the State Treasury to the credit of the Global Payment Program Special Fund.

(2) The Global Payment Program Special Fund shall consist of moneys that a designated public hospital or affiliated governmental agency or entity elects to transfer to the department for deposit into the fund as a condition of participation in the Global Payment Program, to the extent permitted under Section 433.51 of Title 42 of the Code of Federal Regulations, the Special Terms and Conditions, and any other applicable federal Medicaid laws. Except as otherwise provided in paragraph (3), moneys derived from these intergovernmental transfers in the Global Payment Program Special Fund shall be used as the source for the nonfederal share of Global Payment Program payments authorized under the demonstration project. Any intergovernmental transfer of funds provided for purposes of the Global Payment Program shall be made as specified in this ~~section.~~ section or Section 14184.300. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws and the Special Terms and Conditions, and in the form and manner as required by the department.

(3) The department shall claim federal financial participation for GPP payments using moneys derived from intergovernmental transfers made pursuant to this ~~section,~~

section or Section 14184.300, and deposited in the Global Payment Program Special Fund to the full extent permitted by law. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed only to GPP systems and the governmental agencies or entities to which they are affiliated, as applicable. In the event federal financial participation is not available with respect to a payment under this section or Section 14184.300 and either is not obtained, or results in a recoupment of payments already made, the department shall return any intergovernmental transfer fund amounts associated with the payment for which federal financial participation is not available to the applicable transferring entities within 14 days from the date of the associated recoupment or other determination, as applicable.

(4) As a condition of participation in the Global Payment Program, each designated public hospital or affiliated governmental agency or entity, agrees to provide intergovernmental transfer of funds necessary to meet the nonfederal share obligation as calculated under subdivision (g) for Global Payment Program payments made pursuant to this section or Section 14184.300 and the Special Terms and Conditions. Any intergovernmental transfer of funds made pursuant to this section or Section 14184.300 shall be considered voluntary for purposes of all federal laws. No state General Fund moneys shall be used to fund the nonfederal share of any Global Payment Program payment.

(g) For each scheduled quarterly interim payment, interim yearend payment, and final reconciliation payment pursuant to subdivision (d), the department shall determine the intergovernmental transfer amount for each GPP system as follows:

(1) The department shall determine the amount of the quarterly interim payment, interim yearend payment, or final reconciliation payment, as applicable, that is payable to each GPP system pursuant to subdivision (d). For purposes of these determinations, the redistributed amounts described in paragraph (2) of subdivision (d) shall be disregarded.

(2) The department shall determine the aggregate amount of intergovernmental transfers necessary to fund the nonfederal share of the quarterly interim payment, interim yearend payment, or final reconciliation payment, as applicable, identified in paragraph (1) for all the GPP systems.

(3) With respect to each quarterly interim payment, interim yearend payment, or final yearend reconciliation payment, as applicable, an initial transfer amount shall be determined for each GPP system, calculated as the amount for the GPP system determined in paragraph (1), multiplied by the nonfederal share percentage, as defined in Section 14184.10, and multiplied by the applicable GPP system-specific IGT factor as follows:

(A) Los Angeles County Health System: 1.100.
(B) Alameda Health System: 1.137.
(C) Arrowhead Regional Medical Center: 0.923.
(D) Contra Costa Regional Medical Center: 0.502.
(E) Kern Medical Center: 0.581.
(F) Natividad Medical Center: 1.183.
(G) Riverside University Health System-Medical Center: 0.720.
(H) San Francisco General Hospital: 0.507.
(I) San Joaquin General Hospital: 0.803.
(J) San Mateo Medical Center: 1.325.

(K) Santa Clara Valley Medical Center: 0.706.

(L) Ventura County Medical Center: 1.401.

(4) The initial transfer amount for each GPP system determined under paragraph (3) shall be further adjusted as follows to ensure that sufficient intergovernmental transfers are available to make payments to all GPP systems:

(A) With respect to each quarterly interim payment, interim yearend payment, or final reconciliation payment, as applicable, the initial transfer amounts for all GPP systems determined under paragraph (3) shall be added together.

(B) The sum of the initial transfer amounts in subparagraph (A) shall be subtracted from the aggregate amount of intergovernmental transfers necessary to fund the payments as determined in paragraph (2). The resulting positive or negative amount shall be the aggregate positive or negative intergovernmental transfer adjustment.

(C) Each GPP system-specific IGT factor, as specified in subparagraphs (A) to (L), inclusive, of paragraph (3) shall be subtracted from 2.000, yielding an IGT adjustment factor for each GPP system.

(D) The IGT adjustment factor calculated in subparagraph (C) for each GPP system shall be multiplied by the positive or negative amount in subparagraph (B), and multiplied by the allocation percentage determined for the GPP system in paragraph (4) of subdivision (c), yielding the amount to be added or subtracted from the initial transfer amount determined in paragraph (3) for the applicable GPP system.

(E) The transfer amount to be paid by each GPP system with respect to the applicable quarterly interim payment, interim yearend payment, or final reconciliation payment, shall equal the initial transfer amount determined in paragraph (3) as adjusted by the amount determined in subparagraph (D).

(5) Upon the determination of the redistributed amounts described in paragraph (2) of subdivision (d) for the final reconciliation payment, the department shall, with respect to each GPP system that exceeded its respective threshold, determine the associated intergovernmental transfer amount equal to the nonfederal share that is necessary to draw down the additional payment, and shall include this amount in the GPP system's transfer amount.

(h) The department may initiate audits of GPP systems' data submissions and reports, and may request supporting documentation. Any audits conducted by the department shall be complete within 22 months of the end of the applicable GPP program year to allow for the appropriate finalization of payments to the participating GPP system, but subject to recoupment if it is later determined that federal financial participation is not available for any portion of the applicable payments.

(i) If the department determines, during the course of the demonstration term and in consultation with participating GPP systems, that the Global Payment Program should be terminated for subsequent years, the department shall terminate the Global Payment Program by notifying the federal Centers for Medicare and Medicaid Services in accordance with the timeframes specified in the Special Terms and Conditions. In the event of this type of termination, the department shall issue a declaration terminating the Global Payment Program and shall work with the federal Centers for Medicare and Medicaid Services to finalize all remaining payments under the Global Payment Program. Subsequent to the effective date for any termination accomplished pursuant to this subdivision, the designated public hospitals that participated in the Global Payment Program shall claim and receive disproportionate share hospital payments,

if eligible, as described in subparagraph (D) of paragraph (4) of subdivision (b) of Section 14184.30, but only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(j) Commencing January 1, 2021, the Global Payment Program shall be continued as modified pursuant to Section 14184.300.

SEC. 14. Article 5.51 (commencing with Section 14184.100) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.51. California Advancing and Innovating Medi-Cal Act

14184.100. (a) This article shall be known, and may be cited, as the California Advancing and Innovating Medi-Cal (CalAIM) Act.

(b) The implementation of CalAIM, as set forth in this article and the CalAIM Terms and Conditions, shall support all of the following goals:

(1) Identify and manage the risk and needs of Medi-Cal beneficiaries through whole person care approaches and addressing social determinants of health.

(2) Transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility.

(3) Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

14184.101. For purposes of this article, and elsewhere in law where specified, the following definitions shall apply:

(a) "CalAIM" or "CalAIM initiative" means the respective components of the California Advancing and Innovating Medi-Cal initiative approved by the federal Centers for Medicare and Medicaid Services in the CalAIM Terms and Conditions.

(b) "CalAIM term" means the entire period during which an applicable component of the CalAIM initiative is in effect, as approved by the federal Centers for Medicare and Medicaid Services, including any applicable extension period.

(c) "CalAIM Terms and Conditions" means those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services, including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative. CalAIM Terms and Conditions shall include, at a minimum, any terms and conditions specified in the following:

(1) California Advancing and Innovating Medi-Cal Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1315 of Title 42 of the United States Code, effective for the period from January 1, 2022 to December 31, 2026, inclusive, and any applicable extension period, or for any period otherwise approved therein.

(2) Any associated Medicaid Waivers as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1396n of Title 42 of the United States Code that are necessary to implement a CalAIM component, effective for the period from January 1, 2022 to December 31, 2026, inclusive, and any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

(3) Any associated Medi-Cal State Plan amendments approved by the federal Centers for Medicare and Medicaid Services that are necessary to implement a CalAIM component.

(4) Any comprehensive risk contract, nonrisk contract, intergovernmental agreement, or other similar arrangement approved by the federal Centers for Medicare and Medicaid Services to implement the authorities described in paragraph (1), (2), or (3).

(d) "CalAIM year" or "Initiative Year" means the applicable effective period identified in the CalAIM Terms and Conditions that corresponds to a specific period of time as set forth in paragraphs (1) to (5), inclusive. Individual programs or components under the CalAIM Initiative may be operated on program years that differ from the CalAIM years identified in paragraphs (1) to (5), inclusive, or may be operated without regard to program years, as applicable.

(1) Initiative year 1 corresponds to the period of January 1, 2022, to December 31, 2022, inclusive.

(2) Initiative year 2 corresponds to the period of January 1, 2023, to December 31, 2023, inclusive.

(3) Initiative year 3 corresponds to the period of January 1, 2024, to December 31, 2024, inclusive.

(4) Initiative year 4 corresponds to the period of January 1, 2025, to December 31, 2025, inclusive.

(5) Initiative year 5 corresponds to the period of January 1, 2026, to December 31, 2026, inclusive.

(e) "Comprehensive risk contract" shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(f) "Designated public hospital" means any one of the hospitals identified in subdivision (f) of Section 14184.10, and any successor, including any restructured, reorganized, or differently named hospital, that is operated by a county, a city and county, the University of California, or special hospital authority described in Chapter 5 (commencing with Section 101850) or Chapter 5.5 (commencing with Section 101852) of Part 4 of Division 101 of the Health and Safety Code, or any additional public hospital to the extent identified as a "designated public hospital" in the CalAIM Terms and Conditions.

(g) "Federal disproportionate share hospital allotment" means the amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for a federal fiscal year.

(h) "Federal medical assistance percentage" means the federal medical assistance percentage applicable for federal financial participation purposes for medical assistance under the Medi-Cal State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United States Code.

(i) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200).

(j) "Nonrisk contract" shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(k) "Nonfederal share percentage" means the difference between 100 percent and the applicable federal medical assistance percentage.

(*l*) "Total computable disproportionate share hospital allotment" means the federal disproportionate share hospital allotment for a federal fiscal year, divided by the applicable federal medical assistance percentage with respect to that same federal fiscal year.

14184.102. (a) Consistent with federal law, the department shall seek federal approval for, and implement, the CalAIM initiative, including, but not limited to, all of the following components:

(1) Continuation of the Medi-Cal Managed Care program, described in part in Sections 14184.200 to 14184.208, inclusive, and, elsewhere in this chapter and Chapter 8 (commencing with Section 14200), and which includes any comprehensive risk contract between the department and an individual, organization, or entity to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200).

(2) Continuation of the Global Payment Program, described in Section 14184.40, as amended by the act that added this section, and Section 14184.300.

(3) Continuation of the Specialty Mental Health Services Program, as described in part in Section 14184.400.

(4) Continuation of the Drug Medi-Cal Organized Delivery System program, as described in part in Section 14184.401.

(5) Behavioral Health Medical Necessity Changes, Payment Reform, and Administrative Simplification, as described in Sections 14184.402, 14184.403, and 14184.404.

(6) The State Plan Dental Improvement Program, as described in Section 14184.500.

(7) Enhancing County Oversight and Monitoring, as described in Section 14184.600.

(b) In the event of a conflict between any provision of this article and the CalAIM Terms and Conditions, the CalAIM Terms and Conditions shall control.

(c) The department, as appropriate and to the extent practicable, shall consult with interested stakeholders with regard to implementation of applicable components of CalAIM under subdivision (a) in which they will participate, including, but not limited to, the issuance of departmental guidance pursuant to subdivision (d). Interested stakeholders may include, but need not be limited to, designated public hospitals, district and municipal public hospitals, other local governmental agencies, and Medi-Cal managed care plans.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part I of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article or the CalAIM Terms and Conditions, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action. The department shall make use of appropriate processes to ensure that affected stakeholders are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments related to the applicable CalAIM component are finalized.

(e) For purposes of implementing this article or the CalAIM Terms and Conditions, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, and may implement changes to existing information technology systems. Notwithstanding any other law, contracts entered into or amended, or changes to existing information technology systems, pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(f) The department shall seek any federal approvals it deems necessary to implement CalAIM, and this article and other provisions of law amended by the act that added this subdivision. This shall include, but need not be limited to, approval of any amendment, addition, or technical correction to the CalAIM Terms and Conditions, as the department deems necessary. This article shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(g) The director may modify any provision, process, or methodology specified in this article, Article 5.4 (commencing with Section 14180), Article 5.5 (commencing with Section 14184), or other sections of law amended by the act that added this subdivision, to the extent necessary to comply with federal law or the CalAIM Terms and Conditions, to obtain or maintain federal approval, or to ensure federal financial participation is available and not otherwise jeopardized, but only if the modification is consistent with the goals set forth in this article and its individual components, and does not significantly alter the relative level of support for participating entities. The director shall not propose any modification pursuant to this section until the Department of Finance has reviewed and approved a fiscal impact statement. If the director, after consulting with those entities participating in the applicable CalAIM component and that would be affected by that modification, determines that the potential modification would be consistent with the goals set forth in this article and would not significantly alter the relative level of support for affected participating entities, the modification shall be made and the director shall execute a declaration stating that this determination has been made. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature, and shall work with the affected participating entities and the Legislature to make the necessary statutory changes. The director shall post the declaration on the department's internet website and the director shall send the declaration to the Secretary of State and the Legislative Counsel.

(h) During the course of the CalAIM term, the department may develop and implement successor payment methodologies or programs to continue to support entities participating in one or more components of CalAIM following the expiration of the CalAIM term and that further the goals set forth in this article. The department shall consult with the entities participating in the payment methodologies or program components under CalAIM, affected stakeholders, and the Legislature in the development of any successor payment methodologies or program components pursuant to this subdivision.

(i) The department may seek to extend the payment methodologies or programs described in this article, or in the CalAIM Terms and Conditions, including modification thereto, through the CalAIM term or to subsequent time periods by way of amendment or extension of the relevant CalAIM Terms and Conditions, amendment to the Medi-Cal State Plan, or any combination thereof, consistent with the applicable federal requirements. This subdivision shall only be implemented after consultation with the entities participating in, or affected by, those methodologies or programs, and only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(j) Notwithstanding any other state or local law, including, but not limited to, Section 5328 of this code and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health, social services, housing, and criminal justice information, records, and other data with and among the department, other state departments, including the State Department of Public Health and the State Department of Social Services, Medi-Cal managed care plans, Medi-Cal Behavioral Health Delivery Systems, counties, health care providers, social services organizations, care coordination and case management teams, and other authorized provider or plan entities, and contractors of all of those entities, shall be permitted to the extent the department determines necessary to implement applicable CalAIM components described in this article and the CalAIM Terms and Conditions, and to the extent consistent with federal law.

14184.200. (a) Notwithstanding any other law, the department shall standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, in accordance with the CalAIM Terms and Conditions and as described in this section.

(b) (1) Notwithstanding any other law, commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, all non-dual eligible beneficiaries, except those identified in paragraph (2), shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) Notwithstanding any other law, commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the following dual and non-dual beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in a Medi-Cal managed care plan:

(A) Beneficiaries eligible for only restricted-scope Medi-Cal benefits, as described in subdivision (d) of Section 14007.5.

(B) Beneficiaries made eligible on the basis of a share of cost, including, but not limited to, non-dual eligible beneficiaries residing in a county that is authorized to operate a county organized health system (COHS) as described in Article 2.8 (commencing with Section 14087.5), except for non-dual eligible beneficiaries that are eligible on the basis of their need for long-term care services with a share of cost, as identified by the department.

(C) Beneficiaries made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, as determined by the department, but only during the relevant period of presumptive eligibility.

(D) Eligible beneficiaries who are inmates of a public institution, or who are released pursuant to Section 26605.6 or 26605.7 of the Government Code.

(E) Eligible, noncitizen beneficiaries eligible for pregnancy-related Medi-Cal coverage, excluding beneficiaries enrolled in the Medi-Cal Access Program described in Chapter 2 (commencing Section 15810) of Part 3.3.

(F) Non-dual eligible beneficiaries who are Indians as defined in subdivision (a) of Section 438.14 of Title 42 of the Code of Federal Regulations and elect to forego voluntary enrollment in a Medi-Cal managed care plan.

(G) Until the effective date of any necessary federal approvals obtained by the department to implement a specialized model of care pursuant to subdivision (e), non-dual eligible beneficiaries eligible on the basis of their receipt of services through any state foster care program, or eligible pursuant to Section 14005.28, who elect to forego voluntary enrollment in a Medi-Cal managed care plan, except for those non-dual beneficiaries described in this subparagraph who reside in a county that is authorized to operate a county organized health system (COHS) as described in Article 2.8 (commencing with Section 14087.5).

(H) Non-dual eligible beneficiaries enrolled with any entity with a contract with the department pursuant to the Program of All-Inclusive Care for the Elderly (PACE) as described in Chapter 8.75 (commencing with Section 14591).

(I) Any other non-dual eligible beneficiaries, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

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

(c) (1) Notwithstanding any other law, commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, all dual eligible beneficiaries, except as provided in paragraph (2) of subdivision (b) or paragraph (2) of this subdivision, shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) The following dual-eligible beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in Medi-Cal managed care as described in paragraph (1).

(A) Dual eligible beneficiaries made eligible on the basis of a share of cost, including, but not limited to, dual eligible beneficiaries residing in a county that is authorized to operate a county organized health system (COHS) as described in Article 2.8 (commencing with Section 14087.5), except for dual eligible beneficiaries who are eligible on the basis of their need for long-term care services with a share of cost, as determined by the department.

(B) Dual eligible beneficiaries enrolled with any entity with a contract with the department pursuant to the Program of All-Inclusive Care for the Elderly (PACE) as described in Chapter 8.75 (commencing with Section 14591).

(C) Dual eligible beneficiaries enrolled with any entity with a Senior Care Action Network (SCAN) contract with the department.

(D) Dual eligible beneficiaries who are Indians as defined in subsection (a) of Section 438.14 of Title 42 of the Code of Federal Regulations and elect to forego voluntary enrollment in a Medi-Cal managed care plan.

(E) Until the effective date of any necessary federal approvals obtained by the department to implement a specialized model of care pursuant to subdivision (e), dual

eligible beneficiaries eligible on the basis of their receipt of services through any state foster care program, or eligible pursuant to Section 14005.28, who elect to forego voluntary enrollment in a Medi-Cal managed care plan, except for those dual beneficiaries described in this subparagraph who reside in a county that is authorized to operate a county organized health system (COHS) as described in Article 2.8 (commencing with Section 14087.5).

(F) Dual eligible beneficiaries residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(G) Any other dual eligible beneficiaries, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(d) (1) This section shall not be construed to prohibit a Medi-Cal beneficiary from receiving covered benefits on a temporary basis through the Medi-Cal Fee-for-Service delivery system pending enrollment into an individual Medi-Cal managed care plan in accordance with this section and the CalAIM Terms and Conditions.

(2) This section shall not be construed to prohibit certain Medi-Cal beneficiaries eligible for full-scope benefits under the Medi-Cal State plan, as identified by the department, from voluntarily enrolling in a Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(e) (1) In consultation with the State Department of Social Services, the department shall develop a specialized model of care for Medi-Cal beneficiaries eligible on the basis of their receipt of services through any state foster care program or eligible pursuant to Section 14005.28.

(2) During the CalAIM term, the department may seek any necessary federal approvals to authorize and implement the specialized model of care for foster care children and former foster care youth, developed pursuant to paragraph (1).

(3) Until the effective date of any necessary federal approvals obtained by the department pursuant to paragraph (2), Medi-Cal beneficiaries eligible on the basis of their receipt of services through any state foster care program, or eligible pursuant to Section 14005.28, shall continue to receive covered benefits through applicable Medi-Cal delivery systems as they did as of December 31, 2021.

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

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

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

assistance under the Medi-Cal State Plan. For purposes of this article, "dual eligible beneficiary" shall include both "full-benefit dual eligible beneficiaries" and "partial-benefit dual eligible beneficiaries," as those terms are defined in this subdivision.

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

(3) "Non-dual eligible beneficiary" means an individual eligible for medical assistance under the Medi-Cal State plan, as determined by the department, that is not eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

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

14184.201. (a) Notwithstanding any other law, a Medi-Cal managed care plan, pursuant to its comprehensive risk contract with the department, shall provide coverage for those health care services or benefits that are both of the following:

(1) Authorized for receipt of federal financial participation in the Medi-Cal State Plan, or waiver thereof, or otherwise required pursuant to federal law, as determined by the department.

(2) Included by the department as a capitated benefit or otherwise made the financial obligation of the Medi-Cal managed care plan pursuant to its comprehensive risk contract with the department.

(b) A Medi-Cal managed care plan may also be contractually required by the department to provide coverage for a health care service or benefit that does not meet the criteria set forth in subdivision (a) to the extent that sufficient state-only funds are appropriated to the department for that purpose in an applicable state fiscal year.

(c) Notwithstanding any other law, the department shall standardize those applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care in accordance with this section and the CalAIM Terms and Conditions.

(d) (1) (A) Notwithstanding any other law, commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, institutional long-term care services as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing institutional long-term care services to a Medi-Cal beneficiary enrolled in that plan, and each network provider of institutional long-term care services shall accept as payment in full, the amount the network provider of institutional long-term care services could collect if the applicable Medi-Cal beneficiary accessed those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State

Plan and guidance issued pursuant to subdivision (d) of Section 14184.102, unless the Medi-Cal managed care plan and network provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to the department.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and network providers of institutional long-term care services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(e) (1) Notwithstanding any other law, commencing January 1, 2022, the department shall include donor and recipient organ transplant surgeries, as described in Section 14132.69 and in the CalAIM Terms and Conditions, and donor and recipient bone marrow transplants, as described in Section 14133.8 and in the CalAIM Terms and Conditions, as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a network provider furnishing organ or bone marrow transplant surgeries to a Medi-Cal beneficiary enrolled in that plan, and each network provider of organ or bone marrow transplant surgeries shall accept as payment in full, the amount the network provider of organ or bone marrow transplant surgeries could collect if the applicable Medi-Cal beneficiary accessed those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102, unless the Medi-Cal managed care plan and network provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to the department.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and network providers of organ or bone marrow transplant surgeries to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(f) (1) Notwithstanding any other law, commencing January 1, 2022, Community-Based Adult Services (CBAS), as described in Section 14186.3, shall continue to be available as a capitated benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(2) CBAS shall only be available as a covered Medi-Cal benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in an applicable Medi-Cal managed care plan in order to receive those services, except for beneficiaries exempt from mandatory enrollment in a Medi-Cal managed care plan pursuant to the CalAIM Terms and Conditions and Section 14184.200.

(3) CBAS shall be delivered in accordance with applicable state and federal law including, but not limited to, the federal Home and Community-Based Settings

regulations set forth in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) For contract periods during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a network provider furnishing CBAS to a Medi-Cal beneficiary enrolled in that plan, and each network provider of CBAS shall accept as payment in full, the amount the network provider of CBAS could collect if the applicable Medi-Cal beneficiary accessed those services in the Medi-Cal fee-for-service delivery system, as defined by the department in guidance issued pursuant to subdivision (d) of Section 14184.102, unless the Medi-Cal managed care plan and network provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to the department.

(5) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to an applicable Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (4) as applicable. The department may require applicable Medi-Cal managed care plans and network providers of CBAS to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

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

(1) "Comprehensive risk contract" shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Institutional long-term care services" shall have the same meaning as set forth in the CalAIM Terms and Conditions and, subject to subdivision (f) of Section 14184.102, shall include at a minimum all of the following:

(A) Skilled nursing facility services.

(B) Subacute facility services.

(C) Pediatric subacute facility services.

(D) Intermediate care facility services.

(3) "Network provider" shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

14184.203. (a) For contract periods commencing on or after January 1, 2026, the department shall require each Medi-Cal managed care plan and each health plan subcontractor of a Medi-Cal managed care plan to be accredited by the National Committee for Quality Assurance, or an alternative entity pursuant to subdivision (c), in accordance with this section and the CalAIM Terms and Conditions.

(b) The department shall use findings from the accreditation pursuant to subdivision (a) to certify or deem a Medi-Cal managed care plan's compliance with applicable state and federal Medicaid requirements, to the extent the department determines appropriate and upon consultation with affected stakeholders, to the extent practicable.

(c) In the event the department determines that a Medi-Cal managed care plan or an applicable health plan subcontractor thereof is not able to receive accreditation from the National Committee for Quality Assurance due to population size, the department may authorize alternate accreditation so long as the requirements applied are substantially similar to those applied pursuant to subdivision (a), as determined by the department.

(d) After consultation with affected Medi-Cal managed care plans, the department may elect to require that a Medi-Cal managed care plan or applicable health plan subcontractor thereof include in its accreditation pursuant to subdivision (a) one or more of the following:

(1) The Long-term Services and Supports Distinction Survey.

(2) The Medicaid (MED) module.

(3) Other similar surveys or modules identified by the department as appropriate for this purpose.

(e) For purposes of this section, "subcontractor" shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

14184.204. (a) Commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall implement the Population Health Management Program under Medi-Cal Managed Care to improve health outcomes, care coordination, and efficiency through application of standardized health management requirements, in accordance with the CalAIM Terms and Conditions.

(b) The department shall require each Medi-Cal managed care plan to develop and maintain a beneficiary-centered population health management program, which is a model of care and plan of action designed to address member health needs at all points along the continuum of care, as described in the CalAIM Terms and Conditions.

(c) Each population health management program shall, at a minimum, do all of the following:

(1) Prioritize preventive and wellness services.

(2) Identify and assess beneficiary member risks and needs on an ongoing basis.

(3) Manage beneficiary member safety and outcomes during care transitions, across all applicable delivery systems and settings, through effective care coordination.

(4) Identify and mitigate social determinants of health and reduce health disparities or inequities.

14184.205. (a) Subject to subdivision (f) of Section 14184.102, the department shall implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans, in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Subject to the effective dates listed in subdivision (c), the ECM benefit shall be available on a statewide basis to eligible Medi-Cal beneficiaries who are enrolled in an applicable Medi-Cal managed care plan and who meet the criteria in the CalAIM Terms and Conditions for one or more target populations, as determined by the department. ECM shall be available to qualifying dual eligible beneficiaries, as defined in paragraph (1) of subdivision (g) of Section 14184.200, except for those dual eligible beneficiaries enrolled in a Cal MediConnect plan, as defined in paragraph (2) of subdivision (a) of Section 14132.277.

(2) ECM shall only be available as a covered Medi-Cal benefit under a comprehensive risk contract with a Medi-Cal managed care plan. Medi-Cal beneficiaries who are eligible for ECM shall enroll in a Medi-Cal managed care plan in order to receive those services.

(c) (1) Medi-Cal managed care plans operating in counties in which either the Whole Person Care pilot program, pursuant to Section 14184.60, or the Health Home Program, pursuant to Article 3.9 (commencing with Section 14127), or both, were

implemented, as determined by the department, shall be required to cover ECM under their comprehensive risk contract as follows:

(A) Commencing January 1, 2022, Medi-Cal managed care plans described in paragraph (1) shall be required to cover ECM for existing target populations under either the Whole Person Care pilot program or the Health Home Program, or both, as identified by the department.

(B) (i) Commencing July 1, 2022, Medi-Cal managed care plans described in paragraph (1) shall be required to cover ECM for other select target populations described in subdivision (d), as identified by the department.

(ii) Commencing January 1, 2023, Medi-Cal managed care plans described in paragraph (1) shall be required to cover ECM for all target populations described in subdivision (d).

(2) Medi-Cal managed care plans operating in counties in which neither the Whole Person Care pilot program, pursuant to Section 14184.60, nor the Health Home Program, pursuant to Article 3.9 (commencing with Section 14127), was implemented, as determined by the department, shall be required to cover select ECM target populations, as identified by the department, under their comprehensive risk contract, commencing July 1, 2022. All other target populations, including the target population described in paragraph (7) of subdivision (d) shall be covered commencing January 1, 2023.

(d) Target populations of Medi-Cal beneficiaries may include, but need not be limited to, the following, to the extent approved in the CalAIM Terms and Conditions:

(1) Children or youth with complex physical, behavioral, developmental, or oral health needs, including, but not limited to, those eligible for California Children Services, foster care children or youth, or youth with clinical high-risk syndrome or first episode of psychosis.

(2) Individuals experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless.

(3) High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

(4) Individuals at risk for institutionalization and eligible for long-term care services.

(5) Nursing facility residents who want to transition to the community.

(6) Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.

(7) Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

(e) Notwithstanding any other law, for any time period in which a Medi-Cal beneficiary who is eligible to receive ECM services through enrollment in their Medi-Cal managed care plan, the beneficiary shall not receive duplicative targeted case management services as described in Section 14132.44 or otherwise authorized in the Medi-Cal State plan, as determined by the department.

14184.206. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall allow Medi-Cal managed care plans to elect to cover those services or settings approved by the department as cost effective and

medically appropriate in the comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services covered pursuant to subdivision (a) of Section 14184.201, in accordance with the CalAIM Terms and Conditions.

(b) (1) Approved in lieu of services or settings pursuant to this section shall only be available to beneficiaries enrolled in a Medi-Cal managed care plan under a comprehensive risk contract, subject to paragraph (2).

(2) Approved in lieu of services or settings shall not supplant other covered Medi-Cal benefits that are not the responsibility of the Medi-Cal managed care plan under the comprehensive risk contract, including, but not limited to, in-home supportive services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(3) An enrolled Medi-Cal beneficiary shall not be required by their Medi-Cal managed care plan to use the in lieu of service or setting.

(c) Subject to subdivision (f) of Section 14184.102, in lieu of services or settings may include, but need not be limited to, the following when authorized by the department in the comprehensive risk contract with each Medi-Cal managed care plan and to the extent the department determines that the in lieu of service or setting is a cost-effective and medically appropriate substitute for the applicable covered Medi-Cal benefit under the comprehensive risk contract:

(1) Housing transition navigation services.

(2) Housing deposits.

(3) Housing tenancy and sustaining services.

(4) Short-term post-hospitalization housing.

(5) Recuperative care (medical respite).

(6) Respite.

(7) Day habilitation programs.

(8) Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly or adult residential facilities.

(9) Nursing facility transition to a home.

(10) Personal care and homemaker services.

(11) Environmental accessibility adaptations (home modifications).

(12) Medically tailored meals.

(13) Sobering centers.

(14) Asthma remediation.

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

(1) “Comprehensive risk contract” shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) “In lieu of services” shall have the same meaning as set forth in Section 438.3(e)(2) of Title 42 of the Code of Federal Regulations.

14184.207. (a) Commencing January 1, 2022, subject to appropriation by the Legislature in an applicable fiscal year and subdivision (f) of section 14184.102, the department shall make incentive payments available to qualifying Medi-Cal managed care plans that meet predefined milestones and metrics associated with implementation of applicable components of CalAIM, including, but not limited to, Sections 14184.205 and 14184.206, as determined by the department and in accordance with the CalAIM Terms and Conditions.

(b) The department, in consultation with Medi-Cal managed care plans, shall establish the methodology, parameters, and eligibility criteria for incentive payments pursuant to this section. This shall include, but is not limited to, the milestones and metrics that Medi-Cal managed care plans must meet in order to receive an incentive payment pursuant to this section and the CalAIM Terms and Conditions.

(c) The department, in accordance with the CalAIM Terms and Conditions, shall determine if a Medi-Cal managed care plan has earned an incentive payment, and the amount of that payment, for any relevant time period in which this section is implemented.

(d) Incentive payments pursuant to this section shall be made in accordance with the requirements for incentive arrangements described in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

14184.208. (a) (1) Commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall require each Medi-Cal managed care plan operating in Coordinated Care Initiative counties to operate, or continue to operate, a Medicare Advantage Dual Special Needs Plan (D-SNP) in accordance with the CalAIM Terms and Conditions, and in accordance with federal requirements for each D-SNP to have an executed contract with the department, referred to as a State Medicaid Agency Contract (SMAC).

(2) In Coordinated Care Initiative counties beginning in contract year 2023, the department shall only contract with a proposed D-SNP that is affiliated with a Medi-Cal managed care plan or was contracted with the department for a D-SNP in contract year 2022 in the proposed D-SNP service area.

(3) In Coordinated Care Initiative counties beginning with contract year 2023, dual eligible beneficiaries that are not already enrolled in a D-SNP for contract year 2022 may only enroll in a D-SNP that is affiliated with a Medi-Cal managed care plan in the beneficiary's service area.

(b) (1) Commencing January 1, 2025, subject to subdivision (f) of Section 14184.102, the department shall require each Medi-Cal managed care plan to operate, or continue to operate, a D-SNP in accordance with the CalAIM Terms and Conditions, and in accordance with federal requirements for each D-SNP to have an executed contract with the department, referred to as a SMAC.

(2) In non-Coordinated Care Initiative counties beginning no later than contract year 2024, the department shall only contract with a proposed D-SNP that is affiliated with a Medi-Cal managed care plan or was contracted with the department for a D-SNP in the proposed D-SNP service area in the contract year that immediately precedes the contract year in which this paragraph is implemented with respect to an individual county.

(3) In non-Coordinated Care Initiative counties beginning no later than contract year 2024, dual eligible beneficiaries not already enrolled in a D-SNP, in the contract year that immediately precedes the contract year in which this paragraph is implemented with respect to an individual county, may only enroll in a D-SNP that is affiliated with a Medi-Cal managed care plan in the beneficiary's service area. Beginning no later than contract year 2024, D-SNPs that are not affiliated with a Medi-Cal managed care plan shall not accept new enrollment of dual eligible beneficiaries.

(c) To promote more integrated care for dual eligible beneficiaries, the department shall seek to align the enrollment of dual eligible beneficiaries in affiliated Medi-Cal

managed care plans and D-SNPs, in Coordinated Care Initiative counties commencing January 1, 2023, and in all counties commencing January 1, 2025, and in accordance with the CalAIM Terms and Conditions. A dual eligible beneficiary shall not be required to enroll in a D-SNP for purposes of receiving their Medi-Cal benefits.

(d) The department may support requests from D-SNP plans to the federal Centers for Medicare and Medicaid Services to enroll, unless the beneficiary chooses otherwise, existing Medi-Cal managed care beneficiaries into the affiliated D-SNP when the beneficiary becomes newly eligible for Medicare due to age or disability.

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

(1) "Coordinated Care Initiative counties" means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

(2) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this section, "dual eligible beneficiary" shall include both "full-benefit dual eligible beneficiaries" and "partial-benefit dual eligible beneficiaries," as those terms are defined in this subdivision.

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

(4) "Medicare Advantage Dual Special Needs Plan" or "D-SNP" shall have the same meaning as set forth in Section 1395w-28(b)(6) of Title 42 of the United States Code.

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

(f) For purposes of this section, "Medi-Cal managed care plan" shall not include a managed care plan contract with the AIDS Healthcare Foundation.

14184.300. (a) (1) To the extent federal financial participation is available, the department shall continue to implement the Global Payment Program (GPP) as described in Section 14184.40 during the CalAIM term. The department shall continue to administer the GPP in accordance with Section 14184.40, except to the extent changes are approved in the CalAIM Terms and Conditions and except as provided in subdivision (b).

(b) (1) Commencing January 1, 2021, the GPP program year shall be aligned with the calendar year. The department shall provide to the GPP systems a revised schedule for the reporting, notification, intergovernmental transfer, and payment set forth in paragraphs (3) and (4) of subdivision (d) of Section 14184.40, which shall maintain the same conditions and timeline, adjusted by six months to align with the calendar year, and consistent with the CalAIM Terms and Conditions.

(2) Commencing January 1, 2021, the GPP system-specific IGT factors identified in paragraph (3) of subdivision (g) of Section 14184.40 shall be inapplicable and the initial transfer amount calculated for each GPP system shall be identified by the

department and communicated in writing to each GPP system for each applicable GPP program year.

(3) Commencing January 1, 2021, for purposes of determining the applicable GPP's aggregate annual limit, applicable portions of the federal disproportionate share allotment for the federal fiscal year that ends in the GPP program year, and for the federal fiscal year that commences in the applicable GPP program year, shall be appropriately aligned with the GPP program year.

(c) Prior to implementing any of the modifications described in subdivision (b), the department shall consult with the GPP systems.

(d) Except as otherwise provided in the CalAIM Terms and Conditions or in this section, and without limiting the authority in subdivision (g) of Section 14184.102, the rights, obligations, and limitations set forth in Section 14184.40 shall apply to the GPP as continued pursuant to this section.

14184.301. The payment methodologies and requirements described in Section 14184.30, as amended by the act that added this section, shall continue to apply during the entirety of the CalAIM term and any extension periods in which the Global Payment Program pursuant to Section 14184.300 is authorized.

14184.400. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall continue to implement the Specialty Mental Health Services Program described in part in Chapter 8.9 (commencing with Section 14700), as a component of CalAIM and in accordance with the CalAIM Terms and Conditions.

(b) Each mental health plan contracting with the department to provide specialty mental health services pursuant to Chapter 8.9 (commencing with Section 14700) shall comply with all applicable CalAIM Terms and Conditions and any guidance issued by the department pursuant to subdivision (d) of Section 14184.102.

(c) (1) During the CalAIM term, as a component of the Specialty Mental Health Program described in this section, the department, in consultation with counties and other affected stakeholders, may seek federal approval for a demonstration project under Section 1315(a) of Title 42 of the United States Code to receive federal financial participation for services furnished to Medi-Cal beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as Institutions for Mental Diseases. The department may elect to seek approval for this demonstration project to operate on a statewide basis, or on a county-by-county basis.

(2) To the extent the department receives the necessary federal approvals to implement the demonstration project described in subdivision (a), the department shall implement the demonstration in accordance with the terms of that federal approval and only to the extent that federal financial participation is available and is not otherwise jeopardized.

(3) For purposes of this subdivision, "Institutions for Mental Diseases" shall have the same meaning set forth in Section 1396d(i) of Title 42 of the United States Code.

14184.401. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall continue to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) program, previously authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with

Section 14184), as a component of CalAIM and in accordance with the CalAIM Terms and Conditions.

(b) A county, or consortium of counties in a regional model, that elects to administer, or elects to continue to administer, a DMC-ODS pilot shall enter into and maintain an intergovernmental agreement with the department. Those counties shall comply with all applicable CalAIM Terms and Conditions and any guidance issued by the department pursuant to subdivision (d) of Section 14184.102 as a condition of participation.

(c) An election by a county, or consortium of counties in a regional model, to participate as a DMC-ODS pilot shall be considered voluntary for purposes of all state and federal laws.

14184.402. (a) Notwithstanding any other law, commencing no sooner than January 1, 2022, subject to subdivision (f) of Section 14184.102, all medical necessity determinations, screenings, assessments, and documentation associated with covered benefits delivered in any Medi-Cal Behavioral Health Delivery System shall be made in accordance with the CalAIM Terms and Conditions and any written instructions issued by the department pursuant to subdivision (d) of Section 14184.102, including mandatory screening and transition of care tools.

(b) Pursuant to the authority in subdivision (d) of Section 14184.102, the department shall amend, and periodically update as it deems necessary, the medical necessity definitions, criteria, mandatory screening and transition of care tools, documentation requirements and related procedures for Medi-Cal Behavioral Health Delivery Systems.

(c) In the event of a conflict between the CalAIM Terms and Conditions, or the department's written instructions to implement this section pursuant to subdivision (d) of Section 14184.102, and any provision of Chapter 11 (commencing with Section 1810.100) of Division 1 of Title 9 of the California Code of Regulations, or any provision of Chapter 3 (commencing with Section 51000) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations, the CalAIM Terms and Conditions and the department's written instructions shall control.

(d) For purposes of this section, "Medi-Cal Behavioral Health Delivery System" shall mean an entity or local agency that contracts with the department to provide covered behavioral health Medi-Cal benefits pursuant to Article 3.2 (commencing with Section 14124.20), or Section 14184.400 and Chapter 8.9 (commencing with Section 14700), or a county Drug Medi-Cal Organized Delivery System pilot authorized under the CalAIM Terms and Conditions and described in Section 14184.401.

14184.403. (a) Notwithstanding any other law, commencing no sooner than July 1, 2022, subject to subdivision (f) of Section 14184.102, each Medi-Cal Behavioral Health Delivery System shall comply with the behavioral health payment reform provisions approved in the CalAIM Terms and Conditions and any associated instruction issued by the department pursuant to subdivision (d) of Section 14184.102.

(b) As a component of Behavioral Health Payment Reform under CalAIM, the department shall, at a minimum, design and implement an intergovernmental transfer-based reimbursement methodology to replace the use of certified public expenditures for claims associated with covered Specialty Mental Health and Drug Medi-Cal services provided through Medi-Cal Behavioral Health Delivery Systems.

(c) Notwithstanding any other law, commencing no sooner than July 1, 2022, the nonfederal share of any payments associated with each Medi-Cal Behavioral Health Delivery System shall consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or public entities associated with a respective Medi-Cal Behavioral Delivery System. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations, any other applicable federal Medicaid laws, and the CalAIM Terms and Conditions, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this section.

(d) The department shall establish and implement prospective reimbursement rate methodologies utilizing past county cost experience for covered Specialty Mental Health and Drug Medi-Cal services provided by Medi-Cal Behavioral Health Delivery Systems. Those methodologies shall make use of peer groups whereby counties are grouped according to past cost experience, where the department determines appropriate. The department shall determine the frequency of payments and intergovernmental transfers made pursuant to this section.

(e) For purposes of this section, "Medi-Cal Behavioral Health Delivery System" shall mean an entity or local agency that contracts with the department to provide covered behavioral health Medi-Cal benefits pursuant to Article 3.2 (commencing with Section 14124.20), or Section 14184.400 and Chapter 8.9 (commencing with Section 14700), or a county Drug Medi-Cal Organized Delivery System pilot authorized under the CalAIM Terms and Conditions and described in Section 14184.401.

14184.404. (a) Notwithstanding any other law, commencing January 1, 2027, subject to subdivision (f) of Section 14184.102, an individual county, or counties acting jointly, shall provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal Behavioral Health Delivery System contract, in accordance with the CalAIM Terms and Conditions.

(b) During the CalAIM term, the department, in consultation with counties, shall conduct any planning activities it deems necessary and issue related guidance pursuant to subdivision (d) of Section 14184.102 to facilitate implementation of subdivision (a).

(c) The department may authorize a noncounty organization that it contracts with pursuant to subdivision (a) of Section 14712 or Section 14124.21 to provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal Behavioral Health Delivery System contract, in accordance with the CalAIM Terms and Conditions.

(d) For purposes of this section, "Medi-Cal Behavioral Health Delivery System" shall mean an entity or local agency that contracts with the department to provide covered behavioral health Medi-Cal benefits pursuant to Article 3.2 (commencing with Section 14124.20), or Section 14184.400 and Chapter 8.9 (commencing with Section 14700), or a county Drug Medi-Cal Organized Delivery System pilot authorized under the CalAIM Terms and Conditions and described in Section 14184.401.

14184.500. (a) The department shall implement the State Plan Dental Improvement Program in accordance with the CalAIM Terms and Conditions and as described in this section, with the goal of further improving accessibility of Medi-Cal dental services and oral health outcomes for targeted populations, as a successor program to the Dental Transformation Initiative described in Section 14184.70.

(b) Commencing no sooner than January 1, 2021, subject to subdivision (f) of Section 14184.102, the following shall be covered Medi-Cal benefits for the specified populations, when medically necessary and subject to utilization controls:

(1) Caries Risk Assessment bundle for eligible children 0 to 6 years of age, inclusive.

(2) Silver diamine fluoride for eligible children 0 to 6 years of age, inclusive, and for eligible adults residing in skilled nursing facilities or intermediate care facilities or that receive services in facilities overseen by the State Department of Developmental Services, as determined by the department.

(c) (1) Commencing no sooner than January 1, 2021, subject to subdivision (f) of Section 14184.102, the department shall make supplemental payments to qualified dental providers for increased utilization of certain preventive dental services, and for the establishment or maintenance of beneficiary continuity of care through a Dental Home.

(2) The department shall develop the methodology for making supplemental payments pursuant to this subdivision, including, but not limited to, the eligibility criteria for receiving payments, the amount of payments, and the applicable preventive dental services that are eligible for payments.

(A) For payments for increased utilization of certain preventive services, the department shall make a flat-rate supplemental payment to a qualified dental service office location for each eligible paid claim made for those Current Dental Terminology codes specified by the department and approved in the CalAIM Terms and Conditions. To the extent the department deems practicable, the supplemental payment shall be applied at the same time as the underlying eligible paid claim is made.

(B) For payments for the establishment or maintenance of beneficiary continuity of care through a Dental Home, the department shall make a single annual supplemental payment to each eligible service office location based on the number of Medi-Cal beneficiaries for which eligible paid claims were submitted using at least one of Current Dental Terminology exam codes, as specified by the department, in two or more consecutive calendar years.

(d) To the extent permissible under federal law and authorized under the CalAIM Terms and Conditions, for purposes of eligibility for payments described in this section, qualified dental providers may include safety net clinics that provide services defined under subdivision (a) or (b) of Section 14132.100. Supplemental payments made pursuant to this section to safety net clinics shall be considered separate and apart from either the Prospective Payment Service reimbursement for federally qualified health centers or rural health clinics, or Memorandum of Agreement reimbursement for Tribal Health Centers.

(e) The department shall seek federal approval of any state plan amendments it deems necessary to implement subdivisions (b) and (c).

14184.600. (a) Subject to subdivision (f) of Section 14184.102 and in consultation with counties, the department shall develop and implement one or more

initiatives to enhance its oversight and monitoring of county performance in administering the determination of eligibility for benefits under this chapter. This may include, but need not be limited to, the following:

(1) Increased oversight of existing county performance, reporting, and corrective action standards described in Sections 14154 and 14154.5.

(2) A statewide Medi-Cal Eligibility Data System (MEDS) error alert reporting and monitoring program.

(3) A statewide, tiered enforcement framework, consistent with Sections 14154 and 14154.5, to ensure prompt corrective action for counties that do not meet department-established performance or reporting standards, including the imposition of fiscal penalties.

(4) An annual, publicly available performance report for each county.

(b) During the CalAIM term, subject to subdivision (f) of Section 14184.102 and in consultation with counties, the department shall develop and implement one or more initiatives to enhance oversight and monitoring of county administration of the California Children's Services (CCS) program, pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and the Child Health and Disability Prevention (CHDP) program, pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code. This may include, but need not be limited to, the following:

(1) Establish statewide performance, reporting, and budgetary standards, and accompanying audit tools, used to assess county compliance with federal and state requirements applicable to the CCS and CHDP programs.

(2) Conduct periodic CCS and CHDP quality assurance reviews and audits to assess compliance with the standards established in paragraph (1).

(3) Establish a statewide, tiered enforcement framework to ensure prompt corrective action for counties that do not meet standards established in paragraph (1), including the imposition of fiscal penalties.

(4) Require each county to enter into Memoranda of Understanding with the department to document each county's obligations in administering the CCS and CHDP programs.

(c) During the CalAIM term, the department shall convene a workgroup consisting of counties and other applicable stakeholders to develop and implement one or more initiatives designed to improve the collection and use of beneficiary demographic and contact information in administering the Medi-Cal program and other applicable public assistance programs.

SEC. 15. Section 14186 of the Welfare and Institutions Code is amended to read:

14186. (a) It is the intent of the Legislature that long-term services and supports (LTSS) be covered through managed care health plans in Coordinated Care Initiative counties.

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

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

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

(3) Managed care health plans shall, in coordination with LTSS care management providers, develop and expand care coordination practices in consultation with counties, nursing facilities, area agencies on aging, and other home- and community-based providers, and share best practices. Unless the consumer objects, managed care health plans may establish care coordination teams as needed. If the consumer is an IHSS recipient, ~~his or her~~ their participation and the participation of ~~his or her~~ their provider shall be subject to the consumer's consent. These care coordination teams shall include the consumer, and ~~his or her~~ their authorized representative, health plan, Community-Based Adult Services (CBAS) case manager for CBAS clients, Multipurpose Senior Services Program (MSSP) case manager for MSSP clients, and, if an IHSS recipient, may include others, including, but not limited to, the recipient's IHSS provider or a representative of the county social services agency.

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

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

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

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

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

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

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

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

(6) Counties continue to perform functions necessary for the administration of the IHSS program, including conducting assessments and determining authorized hours for recipients, pursuant to Article 7 (commencing with Section 12300) of Chapter 3. Counties and the State Department of Social Services may share recipient and provider data, as legally authorized, related to the IHSS program with managed care health plans for members who are receiving IHSS benefits to support care coordination when applicable.

(7) (A) No sooner than December 31, 2019, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, MSSP services shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit

administered and allocated by managed care health plans in Coordinated Care Initiative counties.

(B) Notwithstanding Chapter 8 (commencing with Section 9560) of Division 8.5, it is also the intent of the Legislature that the provisions of this article shall apply to dual eligible and Medi-Cal-only beneficiaries enrolled in MSSP. It is the further intent of the Legislature that the department and managed care health plans shall work in collaboration with MSSP providers to begin development of standards that create a model of care of an integrated, person-centered care management and care coordination model that works within the context of managed care, and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model to use as the basis of transition planning.

(C) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(D) Notwithstanding any other law, this paragraph shall be operative only through December 31, 2021.

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

(9) Managed care health plans shall share confidential beneficiary data as legally authorized and as appropriate to improve care coordination, promote shared understanding of the consumer's needs, and provide appropriate coordination to the IHSS program and other long-term services and supports.

(10) Managed care health plans may authorize Care Plan Option services, which may include assistance with activities of daily living and instrumental activities of daily living, for which managed care health plans shall be solely responsible for paying. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450 of this code and Sections 1368 and 1368.1 of the Health and Safety Code.

(c) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(d) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 16. Section 14186.1 of the Welfare and Institutions Code is amended to read:

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

(a) "Coordinated Care Initiative counties" has the same meaning as that term is defined in paragraph (1) of subdivision (b) of Section 14182.16.

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

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

(1) In-home supportive services (IHSS) provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956. Notwithstanding any other law, this paragraph shall be operative only through December 31, 2017.

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

(3) Multipurpose Senior Services Program (MSSP) services, which include those services approved under a federal home- and community-based services waiver or, beginning no sooner than January 1, 2020, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, equivalent services. Notwithstanding any other law, this paragraph shall be operative only through December 31, 2021.

(4) Skilled nursing facility services and subacute care services established under subdivision (c) of Section 14132, including those services described in Sections 51511 and 51511.5 of Title 22 of the California Code of Regulations, regardless of whether the service is included in the basic daily rate or billed separately, and any leave of absence or bed hold provided consistent with Section 72520 of Title 22 of the California Code of Regulations or the state plan. However, services provided by any category of intermediate care facility for the developmentally disabled shall not be considered long-term services and supports.

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

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

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

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

(h) "Stakeholder" shall include, but not be limited to, area agencies on aging and independent living centers.

(i) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(j) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 17. Section 14186.2 of the Welfare and Institutions Code is amended to read:

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

(2) HCBS plan benefits may be covered services that are provided under managed care health plan contracts for beneficiaries residing in Coordinated Care Initiative counties, except for the exemptions provided for in subdivision (c).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the department or its enrollment contractor shall notify a beneficiary who is required to receive Medi-Cal long-term care services and supports through a managed care plan and who is potentially eligible for PACE that ~~he or she~~ they may alternatively request to be assessed for eligibility for PACE, and, if eligible, may enroll in PACE. The department or its enrollment contractor shall not enroll a beneficiary who requests to be assessed for PACE in a managed care plan until the earlier of 60 days or the time that ~~he or she is~~ they are assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a managed care plan. During the time that the beneficiary is being assessed, ~~he or she~~ they shall remain in fee-for-service Medi-Cal, or, if applicable, the managed care plan in which ~~he or she is~~ they are enrolled.

(e) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(f) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 18. Section 14186.3 of the Welfare and Institutions Code is amended to read:

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

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

(3) CBAS shall be delivered in accordance with applicable state and federal law including, but not limited to, the federal Home and Community-Based Settings regulations described in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, CBAS shall continue to be available as a Medi-Cal benefit only through managed care health plans in accordance with subdivision (f) of Section 14184.201.

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

(2) Notwithstanding the implementation date authorized in paragraph (1) of subdivision (a) of Section 14186.2, no later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4), whichever is earlier:

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

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

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

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

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

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

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

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

(4) (A) No sooner than December 31, 2019, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of this paragraph, whichever is earlier, MSSP services in Coordinated Care Initiative counties shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans.

(B) No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the transition plan.

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

(D) Before MSSP services transition to a benefit administered and allocated by managed care health plans pursuant to subparagraph (A) of paragraph (2), the California

Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop readiness criteria for the transition. The readiness criteria shall include, but are not limited to, the mutual agreement of the affected managed care health plans and MSSP providers to the transition date. The department shall evaluate the readiness of the managed care health plans and MSSP providers to commence the transition of MSSP services to managed care health plans.

(E) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(5) Notwithstanding any other law, this subdivision shall be operative only through December 31, 2021.

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

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

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

(4) When a managed care health plan has authorized services in a facility and there is a change in the beneficiary's condition under which the facility determines that the facility may no longer meet the needs of the beneficiary, the beneficiary's health has improved sufficiently so the resident no longer needs the services provided by the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, the managed care health plan shall arrange and coordinate a discharge of the beneficiary and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

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

(d) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(e) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 19. Section 14186.4 of the Welfare and Institutions Code is amended to read:

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

(b) To implement this article, the department may contract with public or private entities. Contracts, or amendments to current contracts, entered into under this article may be on a noncompetitive bid basis and shall be exempt from all of the following:

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

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

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

(4) Review or approval of feasibility study reports and the requirements of Sections 4819.35 to 4819.37, inclusive, and Sections 4920 to 4928, inclusive, of the State Administrative Manual.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and State Department of Social Services may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the departments shall notify and consult with stakeholders, including beneficiaries, providers, area agencies on aging, independent living centers, and advocates.

(d) Beginning July 1, 2012, the department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of any report submitted to the federal Centers for Medicare and Medicaid Services (CMS) that is required under an approved federal waiver or waiver amendments or any state plan amendment for any long-term services and supports.

(e) The department shall enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's oversight and readiness review activities specified in this article. These activities may include providing consumer assistance to beneficiaries affected by this article, and conducting financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in this article. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of the Department of Managed Health Care and the department. The department shall not delegate its authority as the single state Medicaid agency under this article to the Department of Managed Health Care. Notwithstanding any law, this subdivision shall be operative only through June 30, 2017.

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

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

(B) The department shall require managed care health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is noncompliant with one or more of the measures set forth in this section, the health plan shall submit, within 60 days, a corrective action plan to the department for approval. The corrective action plan shall include, at a minimum, steps that the health plan shall take to improve its performance based on the standard or standards with which the health plan is out of compliance. The corrective action plan shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14197.7. This paragraph does not limit the application of Section 14197.7.

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

(g) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(h) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 20. Section 14197.4 of the Welfare and Institutions Code is amended to read:

14197.4. (a) The Legislature finds and declares all of the following:

(1) Designated public hospital systems play an essential role in the Medi-Cal program, providing high-quality care to a disproportionate number of low-income Medi-Cal and uninsured populations in the state. Because Medi-Cal covers approximately one-third of the state's population, the strength of these essential public health care systems is of critical importance to the health and welfare of the people of California.

(2) Designated public hospital systems provide comprehensive health care services to low-income patients and lifesaving trauma, burn, and disaster-response services for entire communities, and train the next generation of doctors and other health care professionals, such as nurses and paramedical professionals, who are critical to new team-based care models that achieve more efficient and patient-centered care.

(3) The Legislature intends to continue to provide levels of support for designated public hospital systems in light of their reliance on Medi-Cal funding to provide quality care to everyone, regardless of insurance status, ability to pay, or other circumstance, the significant proportion of Medi-Cal services provided under managed care by these public hospital systems, and new federal requirements related to Medicaid managed care.

(4) It is the intent of the Legislature that Medi-Cal managed care plans and designated public hospital systems that may enter into contracts to provide services for Medi-Cal beneficiaries shall in good faith negotiate for, and implement, contract rates, the provision and arrangement of services and member assignment that are sufficient to ensure continued participation by Medi-Cal managed care plans and designated public hospital systems and to maintain access to services for Medi-Cal managed care beneficiaries and other low-income patients.

(5) It is the intent of the Legislature that, in order to ensure both the financial viability of Medi-Cal managed care plans and support the participation of designated public hospital systems in Medi-Cal managed care, the department shall provide Medi-Cal managed care plans actuarially sound rates reflecting the directed contract services payments implemented to comply with the new federal requirements relating to Medicaid managed care.

(b) Commencing with the 2017–18 state fiscal year, and for each state fiscal year or rate year, as applicable, thereafter, and notwithstanding any other law, the department shall require each Medi-Cal managed care plan to increase contract services payments to the designated public hospital systems by amounts determined under a directed payment methodology that meets federal requirements and as described in this subdivision. The directed payments may be determined and applied as distributions from directed payment pools, as a uniform percentage increase, or other basis, and may incorporate acuity adjustments or other factors.

(1) The directed payments may separately account for inpatient hospital services and noninpatient hospital services. The directed payments shall be developed and applied separately for classes of designated public hospital systems. The department, in consultation with the designated public hospital systems, shall establish the classes of designated public hospital systems consistent with the objectives set forth in subdivisions (a) and (d) and that take into account differences in services provided, service delivery systems, and in the level of risk assumed from managed care plans. The factors to be considered shall include, but are not limited to, operation by the University of California, designated public hospital systems comprised of multiple acute care hospitals, level 1 or level 2 trauma designation, and the assumption of risk for the provision of inpatient hospital services.

(2) To the extent permitted by federal law and to meet the objectives identified in subdivisions (a) and (d), the department shall develop and implement the directed payment program in consultation with designated public hospital systems or Medi-Cal managed care plans, or both, as follows:

(A) The department, in consultation with the designated public hospital systems, shall annually determine on a prospective basis the aggregate amount of payments that will be directed to each class of designated public hospital systems pursuant to this subdivision and the classification of each designated public hospital system. Once the department determines the classification for each designated public hospital system for a particular state fiscal year or rate year, that classification shall not be eligible to change until no sooner than the subsequent ~~state fiscal~~ year. For state fiscal years or rate years following the 2017–18 state fiscal year, the aggregate amounts of payments to a class of designated public hospital systems shall account for trend adjustments to the aggregate amounts available during the prior ~~state fiscal~~ year, subject to any modifications to account for changes in the classification of designated public hospital

systems, changes required by federal law, changes to account for the size of the payments made pursuant to subdivision (c), or other material changes.

(B) The department, in consultation with the designated public hospital systems, shall develop the methodologies for determining the required directed payments for each designated public hospital system.

(C) To the extent necessary to meet the objectives identified in subdivisions (a) and (d) or to comply with federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify the amounts of the aggregate directed payments for any class of designated public hospital systems, the method for determining the distribution of the directed payment amounts within any class of designated public hospital systems, and may modify, consolidate, or subdivide the classes of designated public hospital systems established pursuant to paragraph (1).

(D) After the aggregate amounts and the distribution methodology of directed payments for each designated public hospital system class have been established, the department shall consult with the designated public hospital systems and each affected Medi-Cal managed care plan with regard to the impact on the Medi-Cal managed care plan capitation ratesetting process and implementation of the directed payment requirements, including applicable interim and final payment processes, to ensure that 100 percent of the aggregate amounts are paid to the applicable designated public hospital system.

(3) The required directed payment amounts shall be paid by the Medi-Cal managed care plans as adjustments, in a form and manner specified by the department, to the total amounts of contract services payments otherwise paid to the designated public hospital systems.

(4) The directed payments required under this subdivision shall be implemented and documented by each Medi-Cal managed care plan and designated public hospital system in accordance with all of the following parameters and any guidance issued by the department:

(A) A Medi-Cal managed care plan and the designated public hospital systems shall determine the manner, timing, and amount of payment for contract services, including through fee-for-service, capitation, or other permissible manner. The rates of payment for contract services agreed upon by the Medi-Cal managed care plan and the designated public hospital system shall be established and documented without regard to the directed payments and quality incentive payments required by this section.

(B) The required directed payment enhancements provided pursuant to this subdivision shall not supplant amounts that would otherwise be payable by a Medi-Cal managed care plan to a designated public hospital system for an applicable state fiscal year or rate year, and the Medi-Cal managed care plan shall not impose a fee or retention amount that would result in a direct or indirect reduction to the amounts required under this subdivision.

(C) A contract between a Medi-Cal managed care plan and a designated public hospital system shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

(D) In the event a Medi-Cal managed care plan subcontracts or delegates responsibility to a separate entity for either or both the arrangement or payment of

services, the Medi-Cal managed care plan shall be responsible for paying the designated public hospital system the directed payment described in this subdivision with respect to the services it provides that are covered by that arrangement. The designated public hospital system and the applicable subcontractor or delegated entity shall work together with the Medi-Cal managed care plan to provide the information necessary to facilitate the Medi-Cal managed care plan's compliance with the payment requirements under this subdivision.

(5) Each state fiscal year, a Medi-Cal managed care plan shall provide to the department, at the times and in the form and manner specified by the department, an accounting of amounts paid or payable to the designated public hospital systems it contracts with, including both contract rates and the directed payments, to demonstrate compliance with this subdivision. To the extent the department determines that a Medi-Cal managed care plan is not in compliance with the requirements of this subdivision, or is otherwise circumventing the purposes thereof, to the material detriment of an applicable designated public hospital system, the department may, after providing notice of its determination to the affected Medi-Cal managed care plan and allowing a reasonable period for the Medi-Cal managed care plan to cure the specified deficiencies, reduce the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal managed care beneficiaries by up to 25 percent in the applicable county, so long as the other Medi-Cal managed care plan or Medi-Cal managed care plans in the applicable county have the capacity to receive the additional default membership. The department's determination whether to exercise discretion under this paragraph shall not be subject to judicial review, except that a Medi-Cal managed care plan that has its default assignment reduced pursuant to this paragraph may bring a writ of mandate under Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department under this paragraph. Nothing in this paragraph shall be construed to preclude or otherwise limit the right of any Medi-Cal managed care plan or designated public hospital system to pursue a breach of contract action, or any other available remedy as appropriate, in connection with the requirements of this subdivision.

(6) Capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and account for the Medi-Cal managed care plan's obligation to pay the directed payments to designated public hospital systems in accordance with this subdivision. The department may require Medi-Cal managed care plans and the designated public hospital systems to submit information regarding contract rates and expected or actual utilization of services, at the times and in the form and manner specified by the department. To the extent consistent with federal law and actuarial standards of practice, the department shall utilize the most recently available data and reasonable projections, as determined by the department, when accounting for the directed payments required under this subdivision, and shall account for additional clinics, practices, or other health care providers added to a designated public hospital system. In implementing the requirements of this section, including the Medi-Cal managed care plan ratesetting process, the department may additionally account for material adjustments, as appropriate under federal law and actuarial standards, as described above, and as determined by the department, to contracts entered into between a Medi-Cal managed care plan or applicable subcontracted or delegated entity and a designated public hospital system.

(c) Commencing with the 2017–18 state fiscal ~~year,~~ year for designated public hospital systems, and commencing with the 2020–21 state fiscal year for district and municipal public hospitals, and for each state fiscal year or rate year, as applicable, thereafter, the department, in consultation with the designated public hospital ~~systems~~ systems, district and municipal public hospitals, and applicable Medi-Cal managed care plans, as applicable, shall establish and implement a program or programs under which a designated public hospital system or a district and municipal public hospital may earn performance-based quality incentive payments from the Medi-Cal managed care plan they contract with in accordance with this subdivision.

(1) Payments shall be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with the designated public hospital systems and applicable Medi-Cal managed care plans, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payment program and parameters for the designated public hospital systems to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy. ~~Measures~~ Through and until June 30, 2020, performance measures pursuant to this subdivision shall not duplicate measures utilized in the PRIME program established pursuant to Section 14184.50.

(B) Each designated public hospital system shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the times and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a designated public hospital system in collecting and distributing information necessary for these reports.

(2) The department, in consultation with each designated public hospital system, shall determine a maximum amount that each class established pursuant to paragraph (1) of subdivision (b) may earn in quality incentive payments for the state fiscal year.

(3) The department shall calculate the amount earned by each designated public hospital system based on its performance score established pursuant to paragraph (1).

(A) This amount shall be paid to the designated public hospital system by each of its contracted Medi-Cal managed care plans. If a designated public hospital system contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the designated public hospital system's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the designated public hospital system and each of the applicable Medi-Cal managed care plans.

(B) A contract between a Medi-Cal managed care plan and designated public hospital system shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

(C) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this subdivision, subject to funding by the department pursuant to paragraph ~~(4)~~. (5).

(4) Commencing with the 2020–21 state fiscal year, payments under this paragraph shall be earned by a district and municipal public hospital based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with district and municipal public hospitals, shall establish a class of district and municipal public hospitals, or multiple classes to the extent federal approval is available, for purposes of payments under this paragraph.

(B) The department, in consultation with district and municipal public hospitals, shall determine a maximum amount that the class, or classes, of district and municipal hospitals established pursuant to subparagraph (A) may earn in quality incentive payments for an applicable state fiscal year.

(C) The department, in consultation with district and municipal public hospitals and applicable Medi-Cal managed care plans, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payments and parameters for district and municipal public hospitals to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy.

(D) Each district and municipal public hospital shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the time and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a district and municipal public hospital in collecting and distributing information necessary for these reports.

(E) The department shall calculate the amount earned by each district and municipal public hospital based on its performance score established pursuant to subparagraphs (C) and (D). This amount shall be paid to the district and municipal public hospital by each of its contracted Medi-Cal managed care plans. If a district and municipal public hospital contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the district and municipal public hospital's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the district and municipal public hospital and each of the applicable Medi-Cal managed care plans.

(F) A contract between a Medi-Cal managed care plan and district and municipal public hospital shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this paragraph.

(G) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this paragraph, subject to funding by the department pursuant to paragraph (5).

~~(4)~~

(5) The department shall provide appropriate funding to each Medi-Cal managed care plan, to account for and to enable them to make the quality incentive payments described in this subdivision, through the incorporation into actuarially sound capitation rates or any other federally permissible method. The amounts designated by the department for the quality incentive payments made pursuant to this subdivision shall be reserved for the purposes of the performance-based quality incentive payment program.

(d) (1) In determining the amount of the required directed payments described in paragraph (2) of subdivision (b), and the aggregate size of the quality incentive payment program described in paragraph (2) of subdivision (c), the department shall consult with designated public hospital systems to establish levels for these payments

that, in combination with one another, are projected to result in aggregate payments that will advance the quality and access objectives reflected in prior payment enhancement mechanisms for designated public hospital systems. To the extent necessary to meet these objectives or to comply with any federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify either or both the directed payments or quality incentive payment program. Once these payment levels are established, the department shall consult with the designated public hospital systems and the Medi-Cal managed care plans in the development of the Medi-Cal managed care rates needed for the directed payments and the structure of the quality incentive payment program.

(2) (A) For the 2017–18 state fiscal year, the department shall, as soon as practicable after receipt of necessary federal approvals pursuant to paragraph (1) of subdivision (g), provide written notice of the directed payment and quality incentive payment amounts established pursuant to this section. A Medi-Cal managed care plan's obligation to pay the directed payments and quality incentive payments required under subdivisions (b) and (c), respectively, to a designated public hospital system for the 2017–18 state fiscal year shall be contingent on the receipt of the written notice described in this subparagraph.

(B) For each annual determination, commencing with the 2018–19 state fiscal year and each state fiscal year or rate year thereafter, the department shall provide written notice, as soon as practicable, to each affected Medi-Cal managed care ~~plan and~~ plan, designated public hospital ~~system~~ system, and, commencing with the 2020–21 state fiscal year, each district and municipal public hospital of the applicable Medi-Cal managed care plan's directed payment amounts, the classification of designated public hospital ~~systems,~~ systems and district and municipal public hospitals, as applicable, quality incentive payment amounts, and any other information deemed necessary for the Medi-Cal managed care plan to fulfill its payment obligations under subdivisions (b) and (c), as applicable, for the subject state fiscal year. If the modification of either or both directed payment amounts or quality incentive payment amounts is necessary after receipt of the written notification, the department shall notify the Medi-Cal managed care ~~plan and~~ plan, designated public hospital ~~system~~ system, and district and municipal public hospital, as applicable, in writing of the revised amounts prior to implementation of the revised amounts.

(e) (1) The provisions of paragraphs (3), (4), and (5) of subdivision (a), paragraphs (3) and (4) of ~~subdivisions (b) and~~ subdivision (b), paragraphs (3) and (5) of subdivision (c), and paragraph (2) of subdivision (d) shall be deemed incorporated into each contract between a designated public hospital system and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought by the designated public hospital system or the Medi-Cal managed care plan directly in a court of competent jurisdiction.

(2) Commencing with the 2020–21 state fiscal year, the provisions of paragraph (4) of subdivision (c) and paragraph (2) of subdivision (d) shall be deemed incorporated into each contract between a district and municipal hospital and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought by the district and municipal public hospital or the Medi-Cal managed care plan directly in a court of competent jurisdiction.

(f) (1) The nonfederal share of the portion of the capitation rates specifically associated with directed payments to designated public hospital systems required under subdivision (b) and for the quality incentive payments established pursuant to subdivision ~~(c)~~ (c), or associated with quality incentive payments to district and municipal public hospital systems pursuant to paragraph (4) of subdivision (c), may consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or district and municipal public hospitals and their affiliated governmental entities, or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee.

(2) (A) When applicable for voluntary intergovernmental transfers described in paragraph (1), the department, in consultation with the designated public hospital systems, shall develop and maintain a protocol to determine the available funding for the nonfederal share associated with payments for each applicable state fiscal year pursuant to this section. The protocol developed and maintained pursuant to this paragraph shall account for any applicable contributions made by public entities to the nonfederal share of Medi-Cal managed care expenditures, including, but not limited to, contributions previously made by those specific public entities for the 2015–16 state fiscal year pursuant to Section 14182.15 or 14199.2, but excluding any contributions made pursuant to Sections 14301.4 and 14301.5. Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(B) When applicable for voluntary intergovernmental transfers described in paragraph (1) that are associated with quality incentive payments to district and municipal public hospital systems, the department, in consultation with district and municipal public hospital systems, shall develop and maintain a protocol to determine the available funding for the nonfederal share associated with payments for each applicable state fiscal year pursuant to paragraph (4) of subdivision (c). Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(g) (1) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(2) For any state fiscal year in which this section is implemented, in whole or in part, and notwithstanding any other law, the department or a Medi-Cal managed care plan shall not be required to make any payment pursuant to Section 14182.15, 14199.2, or 14301.5. Nothing in this section shall be construed to preclude or otherwise impose limitations on payment amounts or arrangements that may be negotiated and agreed to between the relevant parties, including, but not limited to, the continuation of existing or the creation of new quality incentive or pay-for-performance programs in addition

to the quality incentive payment program described in subdivision (c) and contract services payments that may be in excess of the directed payment amounts required under subdivision (b).

(h) (1) The department shall seek any necessary federal approvals for the directed payments and the quality incentive payments set forth in this section.

(2) The department shall consult with the designated public hospital systems with regard to the development of the directed payment levels ~~and~~ established pursuant to subdivision (b) of this section, with designated public hospital systems and district and municipal public hospitals with regard to the size of the quality incentive payments established pursuant to subdivision (c) of this section, and shall consult with ~~both the~~ designated public hospital ~~systems~~ systems, district and municipal hospitals, and Medi-Cal managed care plans with regards to the implementation of payments under this section.

(3) The director, after consultation with the designated public hospital systems and Medi-Cal managed care plans, may modify the requirements set forth in this section to the extent necessary to meet federal requirements or to maximize available federal financial participation. In the event federal approval is only available with significant limitations or modifications, or in the event of changes to the federal Medicaid program that result in a loss of funding currently available to the designated public hospital ~~systems,~~ systems or to the district and municipal public hospitals, the department shall consult with the designated public hospitals system, the district and municipal public hospital, and Medi-Cal managed care ~~plans~~ plans, as applicable, to consider alternative methodologies.

(i) 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 by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected designated public hospital ~~systems~~ systems, the district and municipal public hospitals, and Medi-Cal managed care ~~plans~~ plans, as applicable, are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments made pursuant to this section are finalized.

(j) (1) ~~This section~~ (A) Directed payments and quality incentive payments to designated public hospital systems pursuant to subdivisions (b) and (c) shall cease to be operative on the first day of the state fiscal year beginning on or after the date the department determines, after consultation with the designated public hospital systems, that implementation of this section is no longer financially and programmatically supportive of the Medi-Cal program. This determination shall be based solely on both of the following factors:

~~(A)~~

(i) The projected amount of nonfederal share funds available is insufficient to support implementation of ~~this section~~ the payments to designated public hospital systems pursuant to subdivisions (b) and (c) in the subject state fiscal year or rate year.

~~(B)~~

(ii) The degree to which the payment arrangements for designated public hospital systems will no longer materially advance the goals and objectives reflected in this section and in the department's managed care quality strategy drafted and implemented

pursuant to Section 438.340 of Title 42 of the Code of Federal Regulations in the subject state fiscal year or rate year.

~~(2)~~

(B) In making its determination, the department shall consider all reasonable options for mitigating the circumstances set forth in ~~paragraph (1),~~ subparagraph (A), including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives of this section and the managed care quality strategy.

~~(3)~~

(C) The department shall post notice of the determination on its ~~Internet Web site,~~ internet website, and shall provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(2) (A) Quality incentive payments to district and municipal public hospitals pursuant to subdivision (c) shall cease to be operative on the first day of the state fiscal year beginning on or after the date the department determines, after consultation with the district and municipal public hospitals, that implementation of this section is no longer financially and programmatically supportive of the Medi-Cal program. This determination shall be based solely on both of the following factors:

(i) The projected amount of nonfederal share funds available is insufficient to support implementation of the quality incentive payments to district and municipal hospitals pursuant to subdivision (c) in the subject state fiscal year or rate year.

(ii) The degree to which the payment arrangement for district and municipal hospitals will no longer materially advance the goals and objectives reflected in this section and in the department's managed care quality strategy drafted and implemented pursuant to Section 438.340 of Title 42 of the Code of Federal Regulations in the subject state fiscal year or rate year.

(B) In making its determination, the department shall consider all reasonable options for mitigating the circumstances set forth in subparagraph (A), including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives of this section and the managed care quality strategy.

(3) (C) The department shall post notice of the determination on its internet website, and shall provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(k) The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall provide the Legislature with the federally approved evaluation plan required in Section 438.6(c)(2)(i)(D) of Title 42 of the Code of Federal Regulations to measure the degree to which the payments authorized under this section advance at least one of the goals and objectives of the department's managed care quality strategy. The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall report to the Legislature the results of this evaluation once the department determines that the evaluation is finalized and complete according to the terms of any applicable federal approval and no earlier than January 1, 2021.

(*l*) (1) The department may, after consultation with the designated public hospital ~~systems~~ systems, the district and municipal public hospitals, and Medi-Cal managed care plans, as applicable, exclude certain Medi-Cal managed care enrollee categories of aid, or subcategories thereof, or certain categories of medical assistance provided under a Medi-Cal managed care plan, or subcategories thereof, from the definition of "contract services payments" for purposes of the directed payment requirements described in subdivision (b).

(2) The department shall seek federal approval to implement this subdivision.

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

(1) "Contract services payments" means the amount paid or payable to a designated public hospital system, including amounts paid or payable under fee-for-service, capitation amounts prior to any adjustments for service payment withholds or deductions, or payments made on any other basis, under a network provider contract with a Medi-Cal managed care plan for medically necessary and covered services, drugs, supplies, or other items provided to an eligible Medi-Cal beneficiary enrolled in the Medi-Cal managed care plan, excluding services provided to individuals who are dually eligible for both the Medicare and Medi-Cal programs and any additional exclusions that are approved pursuant to subdivision (*l*). Contract services includes all covered services, drugs, supplies, or other items the designated public hospital system provides, or is responsible for providing, or arranging or paying for, pursuant to a network provider contract entered into with a Medi-Cal managed care plan. In the event a Medi-Cal managed care plan subcontracts or delegates responsibility to a separate entity for either or both the arrangement or payment of services, "contract services payments" also include amounts paid or payable for the services provided by, or otherwise the responsibility of, the designated public hospital system that are within the scope of services of the subcontracted or delegated arrangement so long as the designated public hospital system holds a network provider contract with the primary Medi-Cal managed care plan.

(2) "Designated public hospital" shall have the same meaning as set forth in subdivision (f) of Section 14184.10.

(3) "Designated public hospital system" means a designated public hospital and its affiliated government entity clinics, practices, and other health care providers, including the respective affiliated hospital authority and county government entities described in Chapter 5 (commencing with Section 101850) and Chapter 5.5 (commencing with Section 101852), of Part 4 of Division 101 of the Health and Safety Code.

(4) (A) "Medi-Cal managed care plan" means an applicable organization or entity that enters into a contract with the department pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.82 (commencing with Section 14087.98).

(v) Article 2.91 (commencing with Section 14089).

(vi) Chapter 8 (commencing with Section 14200).

(B) "Medi-Cal managed care plan" does not include any of the following:

(i) A mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

(ii) A plan not covering inpatient services, such as primary care case management plans, operating pursuant to Section 14088.85.

(iii) A Program of All-Inclusive Care for the Elderly organization operating pursuant to Chapter 8.75 (commencing with Section 14591).

(5) "Network provider" shall have the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations, and does not include arrangements where a designated public hospital system or a district and municipal public hospital provides or arranges for services under an agreement intended to cover a specific range of services for a single identified patient for a single inpatient admission, including any directly related followup care, outpatient visit or service, or other similar patient specific nonnetwork contractual arrangement, such as a letter of agreement or single case agreement, with a Medi-Cal managed care plan or subcontractor of a Medi-Cal managed care plan.

(6) "District and municipal public hospital" means a nondesignated public hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98, that is a contracted network provider of one or more Medi-Cal managed care plans, and that had an approved project plan under the PRIME program established pursuant to Section 14184.50 or is otherwise authorized to participate in a quality incentive directed payment program pursuant to the applicable terms of federal approval obtained by the department pursuant to paragraph (1) of subdivision (h).

SEC. 21. Section 14301.1 of the Welfare and Institutions Code is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

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

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

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

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

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

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop

cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(n) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) (A) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

(B) The rate methodology shall be consistent with actuarial rate development principles and shall provide for all reasonable, appropriate, and attainable costs for each PACE organization within a region.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) The department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity of the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), to reflect the lower enrollment and higher operating costs associated with a new PACE organization relative to a PACE organization with higher enrollment and more experience providing managed care interventions to its beneficiaries.

(11) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

(o) (1) Notwithstanding any other law, as a component of the CalAIM Initiative authorized pursuant to Article 5.51 (commencing with Section 14184.100) of Chapter 7, and any successor waiver, demonstration, or state plan amendment authorizing the Medi-Cal managed care program, the department may establish capitation rates to contracted health plans on a regional basis in lieu of health-plan and county-specific rates.

(2) The regional-based rate methodology authorized in this subdivision shall be effective no sooner than the contract rating period commencing on January 1, 2022. Subject to paragraph (4), the department may elect to implement this subdivision in multiple phases with respect to designated regions of the state or Medi-Cal managed care models.

(3) The department, in consultation with affected contracted health plans, shall develop the regional groupings and rate methodologies to be used pursuant to this subdivision, consistent with applicable federal requirements, actuarial methods, and the CalAIM Terms and Conditions as defined in subdivision (c) of Section 14184.101. In developing and implementing any methodology pursuant to this subdivision, the department shall seek to incentivize improved quality and outcomes for Medi-Cal managed care enrollees.

(4) This subdivision shall be implemented only to the extent that the department obtains any necessary federal approvals, and that federal financial participation is available and not otherwise jeopardized.

(p) (1) It is the intent of the Legislature that both affected contracted health plans and the state have appropriate actuarial protections against the risk of either significant overpayments or significant underpayments in capitation rates developed and paid pursuant to this section that are associated with the changes to the Medi-Cal managed care program described in Article 5.51 (commencing with Section 14184.100) of Chapter 7, as identified by the department.

(2) (A) Notwithstanding any other law, as a component of the CalAIM initiative authorized pursuant to Article 5.51 (commencing with Section 14184.100) of Chapter 7, and any successor waiver, demonstration, or state plan amendment authorizing the Medi-Cal managed care program, the department may develop and implement appropriate actuarial methods to prevent significant overpayments or significant underpayments as described in paragraph (1), subject to paragraph (4). This may include, but need not be limited to, one or more of the following:

(i) A medical or profit/loss risk corridor.

(ii) Blended capitation rates based on projected member risk.

(iii) Other prospective or retrospective shared savings or risk models.

(B) The methods or models described in subparagraph (A) shall seek to encourage quality improvement and promote appropriate utilization incentives, including, but not limited to, reduced rehospitalization and shorter lengths of institutional stay.

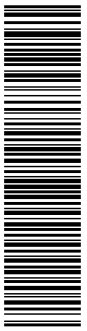
(3) The department shall consult with affected contracted health plans in implementing this subdivision.

(4) This subdivision shall be implemented only to the extent that the department obtains any necessary federal approvals, and that federal financial participation is available and not otherwise jeopardized.

SEC. 22. The Legislature finds and declares that this act is a state law within the meaning of Section 1621(d) of Title 8 of the United States Code.

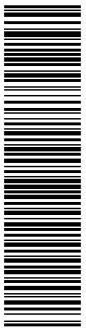
SEC. 23. The provisions of this act are severable. If any provision of this act or its application is held invalid or unconstitutional by a decision of a court of competent jurisdiction, that decision shall not affect the validity of the remaining provisions or applications of this act. The Legislature hereby declares that it would have enacted this bill and each and every provision thereof not declared invalid or unconstitutional without regard to whether any other provision of this act or application thereof would be subsequently declared invalid or unconstitutional.

SEC. 24. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.



LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: California Advancing and Innovating Medi-Cal.



(1) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, either through a fee-for-service or managed care delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would establish the California Advancing and Innovating Medi-Cal (CalAIM) initiative, whose implementation would support the stated goals of identifying and managing the risk and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes, as specified. The bill would require the department to seek federal approval for the CalAIM initiative, and would condition its implementation on receipt of any necessary federal approvals and availability of federal financial participation. The bill would, for implementation purposes, authorize the department to enter into exclusive or nonexclusive contracts, or amend existing contracts, as specified.

(2) Under existing law, Medi-Cal benefits encompass behavioral health services and substance use disorder treatment, provided in part under the Medi-Cal Specialty Mental Health Services (SMHS) Program and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Existing law also establishes the Global Payment Program (GPP), under which designated public hospitals are eligible to receive global payments that are calculated using a value-based point methodology based on the health care that they provide to the uninsured.

This bill would reorganize or repeal some of those provisions but would continue the Medi-Cal managed care system, the GPP, the SMHS Program, and the DMC-ODS through the CalAIM initiative. Under the bill, the initiative would also include behavioral health medical necessity changes, administrative simplification, payment reform, the state plan dental improvement program, and enhancement of county oversight and monitoring.

(3) This bill would make various changes to the Medi-Cal managed care system, including the standardization of populations that are subject to mandatory enrollment, accreditation by the National Committee for Quality Assurance or an alternative entity, implementation of the Population Health Management Program, coverage of enhanced care management and "in lieu of" services, incentive payments to plans and hospitals based on milestones and performance and subject to appropriation, and development of capitation rates and actuarial methods, as specified.

(4) This bill would make changes to the Medi-Cal behavioral health delivery system, including the design of an intergovernmental transfer-based reimbursement methodology, as specified. The bill would, commencing January 1, 2027, require an

individual county, or counties acting jointly, to provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal behavioral health delivery system contract, as specified. By creating new duties for counties relating to behavioral health services, the bill would impose a state-mandated local program.

(5) This bill would, subject to federal approval, require the department to implement the State Plan Dental Improvement Program, with the goal of further improving accessibility of Medi-Cal dental services and oral health outcomes for targeted populations, as specified.

(6) This bill would require the department to develop and implement one or more initiatives to enhance its oversight and monitoring of county performance in administering the determination of eligibility for benefits under the Medi-Cal program, the California Children's Services (CCS) program, and the Child Health and Disability Prevention (CHDP) program. The bill would require each county to enter into memoranda of understanding with the department to document each county's obligations in administering the CCS and CHDP programs. By creating new duties for county officials relating to these programs, the bill would impose a state-mandated local program.

(7) Existing federal law provides for the federal Medicare program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age. Under existing law, a demonstration project known as the Coordinated Care Initiative (CCI) enables beneficiaries who are dually eligible for the Medi-Cal program and the Medicare Program to receive a continuum of services that maximizes access to, and coordination of, benefits between these programs.

This bill would make CCI operative only through December 31, 2020, as specified, and would repeal its provisions on January 1, 2025. The bill would also require Medi-Cal managed care plans to operate, or continue to operate, a Medicare Advantage Dual Special Needs Plan, commencing January 1, 2023, in CCI counties, and commencing January 1, 2025, in all other counties, as specified.

(8) Existing law authorizes the department to create the Health Home Program for Medi-Cal enrollees with chronic conditions, subject to federal approval and the availability of federal financial participation. Existing law generally conditions the implementation of the program on no additional General Fund moneys being used to fund the administration and costs of services.

This bill would, commencing with the 2021–22 state fiscal year, authorize program implementation using General Funds moneys upon appropriation by the Legislature. The bill would require the department to cease implementing the program on January 1, 2022, or as specified, and would repeal the program's provisions on January 1, 2023.

(9) Existing law authorizes the board of supervisors in each county to designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program, as defined, consistent with federal requirements.

This bill would instead, commencing January 1, 2023, require the board of supervisors, in consultation with the county sheriff, to designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process. The bill would make conforming changes to provisions relating to the coordination duties of jail administrators. By creating new duties for local officials, including boards

of supervisors and jail administrators, the bill would impose a state-mandated local program.

The bill would, no sooner than January 1, 2023, require the department to develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for inmates, as specified. The bill would permit the sharing of health information, records, and other data with and among counties and other specified entities to the extent the department determines necessary to implement these provisions.

(10) For purpose of the programs and services described in the paragraphs above, this bill would make conforming changes to provisions relating to the adoption of regulations or issuance of all-county letters by the department.

(11) This bill would make its provisions severable and would make other legislative findings and declarations.

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

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

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