**WELFARE AND INSTITUTIONS CODE - WIC**

**DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98]** *( Division 9 added by Stats. 1965, Ch. 1784. )*

**PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771]** *( Part 3 added by Stats. 1965, Ch. 1784. )*

**CHAPTER 7. Basic Health Care [14000 - 14199.87]** *( Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4. )*

**ARTICLE 5.4. Health Care Coordination, Improvement, and Long-Term Cost Containment Waiver or Demonstration Project [14180 - 14182.9]** *( Article 5.4 added by Stats. 2009, 4th Ex. Sess., Ch. 6, Sec. 2. )*

**14180.** (a) The department shall submit an application to the federal Centers for Medicare and Medicaid Services for a waiver or a demonstration project to implement all of the following:

(1) Strengthen California's health care safety net, which includes disproportionate share hospitals, for low-income and vulnerable Californians.

(2) Maximize opportunities to reduce the number of uninsured individuals.

(3) Optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care.

(4) Promote long-term, efficient, and effective use of state and local funds.

(5) Improve health care quality and outcomes.

(6) Promote home-and community-based care.

(b) The waiver or demonstration project shall include proposals to restructure the organization and delivery of services to be more responsive to the health care needs of Medi-Cal enrollees for the purpose of providing the most vulnerable Medi-Cal beneficiaries with access to better coordinated and integrated care that will improve their health outcomes, slow the long-term growth of the Medi-Cal program, and continue support for the safety net care system and the persons who rely on that system for needed care. These restructuring proposals may include, but are not limited to, the following:

(1) Better care coordination for seniors and persons with disabilities, dual eligibles, children with special health care needs, and persons with behavioral health conditions, which shall include the establishment of organized delivery systems that incorporate a medical home system and care and disease management, as well as incentives that reward providers and beneficiaries for achieving the desired clinical, utilization, and cost-specific outcomes.

(2) Improved coordination between Medicare and Medi-Cal coverage.

(3) Improved coordination of care for children with significant medical needs through improved integration of delivery systems and use of medical homes and specialty centers, and providing incentives for specialty and nonspecialty care.

(4) Improved integration of physical and behavioral health care.

(c) In developing the waiver or demonstration project application, the department shall consult on a regular basis with interested stakeholders and the Legislature.

(d) The department shall determine the form of waiver most appropriate to achieve the purposes listed in subdivision (a).

(e) The department shall submit the waiver or demonstration project application to the federal Centers for Medicare and Medicaid Services by a date that allows sufficient time for the waiver or demonstration project to be approved by no later than September 1,

2010, or the conclusion of any extension period granted in California's Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (No. 11-W-00193/9), whichever happens last.

(f) In order to restructure the Medi-Cal program to improve the delivery of care for specified populations and secure the maximum amount of federal financial participation allowable, any waiver or demonstration project application submitted pursuant to subdivision (a) may specify and seek authority to enroll beneficiaries into specified organized delivery systems. Subject to federal approval, the specified organized delivery systems may include the utilization of an enhanced primary care case management model, a medical home model, or managed care model. The department is authorized to enroll beneficiaries in an organized system of care subject to the conditions in Section 14181. Subject to federal approval, any waiver or demonstration project application submitted pursuant to subdivision (a) shall include processes, and accompanying criteria, by which the department will evaluate and grant exemption, on an individual basis, from this section's requirements pertaining to the mandatory enrollment of beneficiaries in specified organized delivery systems.

(g) (1) The department shall only implement the waiver or demonstration project upon submittal of an implementation plan, pursuant to Section 14181, to the appropriate policy and fiscal committees of the Legislature at least 60 days prior to any appropriation.

(2) Pursuant to paragraph (1), mandatory enrollment in any organized delivery system authorized pursuant to a waiver or demonstration project authorized pursuant to this article shall only occur when funds necessary to support that effort have been appropriated.

(3) It is the intent of the Legislature to neither impede nor limit the department's existing statutory authority regarding the operation of the Medi-Cal program and its health care delivery systems by the enactment of this article.

(h) The director shall have the discretion to utilize state plan amendments, in whole or in part, to accomplish any or all purposes of this article. In the event the director proceeds with state plan amendments as specified, the department shall provide notification in writing to the chairperson of the Joint Legislative Budget Committee within 15 working days of that action and a brief description and purpose of the amendment. This amendment shall be made available to the Joint Legislative Budget Committee upon the request of the chairperson.

*(Added by Stats. 2009, 4th Ex. Sess., Ch. 6, Sec. 2. Effective July 28, 2009.)*

**14181.** (a) The California Health and Human Services Agency or successor entity or designated department shall submit an implementation plan to the appropriate policy and fiscal committees of the Legislature for implementation of the federally approved waiver or demonstration project. The implementation plan shall be developed in consultation with a stakeholder advisory committee established pursuant to subdivision (b). The implementation plan shall specifically address the multiple and complex needs of seniors and persons with disabilities, dual eligibles, children with special health care needs, and persons with behavioral health conditions, and the specific strategies the agency or successor entity or designated department will use to ensure the provision of quality, accessible health care services under the waiver or demonstration project, including, at a minimum, the following elements:

(1) Criteria, performance standards, and indicators shall be adopted to ensure that plan services meet the multiple and complex needs of beneficiaries and comply with the requirements of this article. The performance standards shall incorporate, at a minimum, existing statutory and regulatory requirements and protections applicable to two-plan model and geographic managed care plans, as well as those protections available 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), but in addition shall include specific requirements and standards based on the multiple and complex care needs of seniors and persons with disabilities, dual eligibles, children with special health care needs, and persons with behavioral health conditions, including, but not limited to, standards where applicable to the organized delivery system model in all of the following areas:

(A) Plan readiness.

(B) Availability and accessibility of services, including physical access and communication access.

(C) Benefit management and scope of services.

(D) Care coordination and care management.

(E) Beneficiary complaints, grievances, and appeals.

(F) Beneficiary participation.

(G) Continuity of care.

(H) Cultural and linguistic appropriateness.

(I) Financial management.

(J) Measurement and improvement of health outcomes.

(K) Marketing, assignment, enrollment, and disenrollment.

(L) Network capacity, including travel time and distance and specialty care access.

(M) Performance measurement and improvement.

(N) Provider grievances and appeals.

(O) Quality care.

(P) Recordkeeping and reporting.

(2) Strategies to be used to monitor performance of all contractors and to ensure compliance with all components of the waiver or demonstration project.

(3) Provision of a comprehensive timeline of key milestones for implementation of the waiver or demonstration project components.

(4) Provision of a framework for evaluation of the waiver or demonstration project, including the process, timelines, and criteria for evaluating implementation, as well as the method for providing periodic updates of outcomes and key implementation concerns.

(b) Prior to preparing the implementation plan required by this section, the agency or successor entity or designated department, shall convene a stakeholder committee to advise on preparation of the implementation plan. The stakeholder committee shall include, but not be limited to, persons with disabilities, seniors, and representatives of legal services agencies that serve clients in the affected populations, health plans, specialty care providers, physicians, hospitals, county government, labor, and others as deemed appropriate by the agency or successor entity or designated department. The stakeholder committee shall advise on the implementation of the waiver or demonstration project until the expiration of the waiver or demonstration project.

*(Added by Stats. 2009, 4th Ex. Sess., Ch. 6, Sec. 2. Effective July 28, 2009.)*

**14182.** (a) (1) In furtherance of the waiver or demonstration project developed pursuant to Section 14180, the department may require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new or existing managed care health plans. To the extent that enrollment is required by the department, an enrollee's access to fee-for-service Medi-Cal shall not be terminated until the enrollee has been assigned to a managed care health plan.

(2) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(17) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set (HEDIS) or

measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance (NCQA) Structure and Process measures, or both.

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

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

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

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

(B) To receive notice, including that a new member has been denied a medical exemption as described in paragraph (15), which is required to include the name or names of the requesting provider, and ensure that the provider's ability to treat the member is continued as described in paragraphs (11) and (13), if applicable, or, if not applicable, ensure the member is immediately referred to a qualified provider or specialty care center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) Appropriate involvement of caregivers.

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

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

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

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

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

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

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

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

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

The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to alter medical home elements under this section at least five days in advance of taking this action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(o) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) not in conflict with this article or with the terms and conditions of the demonstration project shall apply to this section.

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

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

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

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

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

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

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

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

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

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

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

*(Amended by Stats. 2013, Ch. 76, Sec. 221. (AB 383) Effective January 1, 2014. Implementation is contingent upon federal funding, pursuant to subd. (g).)*

**14182.1.** (a) Beginning March 2011, the department shall convene a stakeholder workgroup to review the existing encounter, claims, and financial data submission process required by the department under managed care health plan contracts. The workgroup members shall be selected by the department and shall include interested representatives from Medi-Cal managed care health plans, managed care health plan associations, hospitals, individual health care providers, physician groups, and consumer representatives. In reviewing the process, the department shall consider input from the stakeholder workgroup and develop data quality submission standards by October 2011.

(b) Beginning January 1, 2012, managed care health plans shall comply with the quality submission standards developed pursuant to subdivision (a) when submitting data to the department. The director may impose a penalty for each month that a managed care health plan fails to submit data in compliance with these standards. The penalty shall be in proportion to that plan's failure to comply with the data submission standards, as the director in his or her sole discretion determines, and in no event shall the penalty exceed 2 percent of the total monthly capitation rate for that plan.

(c) 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, 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. If the department elects to adopt regulations, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

*(Amended by Stats. 2011, Ch. 296, Sec. 335. (AB 1023) Effective January 1, 2012.)*

**14182.15.** (a) It is the intent of the Legislature that, to the extent that it does not jeopardize other federal funding and is permitted by federal law, the intergovernmental transfers described in this section provide support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate designated public hospitals in a sufficient amount to preserve and strengthen the availability and quality of services provided by those hospitals and their affiliated public providers. It is further the intent of the Legislature that transferring public entities elect to provide intergovernmental transfers in an amount that is at least equivalent to the amount of the nonfederal share that they would provide under fee-for-service, as adjusted for utilization.

(b) (1) In conjunction with the implementation of Section 14182, a public entity may elect 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 Medi-Cal beneficiaries.

(2) For purposes of this section, "public entity" means a designated public hospital as defined in subdivision (d) of Section 14166.1, the University of California, or a county or city and county or local hospital authority that is licensed to operate one or more of the designated public hospitals.

(c) If a public entity elects to make intergovernmental transfers pursuant to this section, all of the following shall apply:

(1) To ensure that the implementation of Section 14182 does not jeopardize the ability of designated public hospitals and their affiliated public providers to continue serving Medi-Cal beneficiaries, to the extent permitted under federal law, the department shall require managed care health plans to pay the designated public hospital and other governmental providers affiliated with the transferring public entity for services rendered to Medi-Cal beneficiaries, amounts that are no less than the amount to which the providers would have otherwise been entitled, including the federal and nonfederal share, on a fee-for-service basis, for the full scope of Medi-Cal services, including supplemental payments and any additional federally permissible amount. The payment amounts required by this paragraph shall be based upon the volume of Medi-Cal services provided by the designated public hospitals and other governmental providers affiliated with the transferring public entity.

(2) Except as provided in Section 14105.24, to the extent that the payments described in paragraph (1) result in increased payments by the managed care health plans to the designated public hospitals and other governmental providers affiliated with the transferring public entity that are the basis of increased rates paid by the department to the managed care health plans above the amount that would have been paid in the absence of paragraph (1), the nonfederal share of the increased rates shall be borne by the transferring entity as described in subdivision (d) and there shall be no additional impact on state General Fund

expenditures. Additionally, the payment rates shall only be paid to the extent they can be certified as actuarially sound and as permitted under federal law.

(d) The department shall meet and confer with the public entities regarding their election to contribute to the nonfederal share of federal Medicaid expenditures under this section and to determine each public entity's intergovernmental transfer amount, which shall be comprised of the following:

(1) An amount that is equivalent to the nonfederal share of the rates of compensation the public entity's designated public hospital would receive from managed care health plans, without regard to the requirement of paragraph (1) of subdivision (c), for Medi-Cal inpatient days of service that otherwise would have been rendered on a fee-for-service basis in the absence of the implementation of Section 14182 to Medi-Cal enrollees who are seniors and persons with disabilities.

(2) An amount that is equivalent to the nonfederal share of the amount which the designated public hospital and other governmental providers affiliated with the transferring entity would have otherwise incurred on a fee-for-service basis for providing Medi-Cal services to the Medi-Cal managed care health plan enrollees they serve, including supplemental payments, excluding the nonfederal share of those amounts the plan will pay for the services without regard to the requirement of paragraph (1) of subdivision (c), and consistent with Section 14105.24, to the extent otherwise applicable.

(3) Amounts equivalent to the nonfederal share of additional federally permissible payments.

(e) Prior to accepting the transfer amounts from a public entity determined under subdivision (d), the department shall ensure that its contracts with the applicable managed care health plans and the contracts between the managed care health plans and the public entities require, to the extent permitted under federal law, that the managed care health plans pay the designated public hospitals, and other governmental providers affiliated with the transferring entities, amounts that are in furtherance of the intent of this section as described in subdivision (a) and consistent with what the designated public hospital and other governmental providers affiliated with the transferring public entity would have received through fee-for-service, and that the payment amounts meet the requirement of paragraph (1) of subdivision (c).

(f) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal matching funds to the maximum extent permitted by federal law.

(g) Participation in intergovernmental transfers under this section is voluntary on the part of the transferring entity for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this section by means of intergovernmental transfers, the transferring entity agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to implementation of this section. This section shall be implemented only to the extent federal financial participation is not jeopardized.

*(Added by Stats. 2010, Ch. 714, Sec. 22. (SB 208) Effective October 19, 2010.)*

**14182.2.** (a) Notwithstanding Section 14094.3, in furtherance of the waiver or demonstration project developed pursuant to Section 14180, the director shall establish, by January 1, 2012, organized health care delivery models for children eligible for California Children Services (CCS) under Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code. These models shall be chosen from the following:

(1) An enhanced primary care case management program.

(2) A provider-based accountable care organization.

(3) A specialty health care plan.

(4) A Medi-Cal managed care plan that includes payment and coverage for CCS-eligible conditions.

(b) Each model shall do all of the following:

(1) Establish clear standards and criteria for participation, exemption, enrollment, and disenrollment.

(2) Provide care coordination that links children and youth with special health care needs with appropriate services and resources in a coordinated manner to achieve optimum health.

(3) Establish networks that include CCS-approved providers and maintain the current system of regionalized pediatric specialty and subspecialty services to ensure that children and youth have timely access to appropriate and qualified providers.

(4) Coordinate out-of-network access if appropriate and qualified providers are not part of the network or in the region.

(5) Ensure that children enrolled in the model receive care for their CCS-eligible medical conditions from CCS-approved providers consistent with the CCS standards of care.

(6) Participate in a statewide quality improvement collaborative that includes stakeholders.

(7) (A) Establish and support medical homes, incorporating all of the following principles:

(i) Each child has a personal physician.

(ii) The medical home is a physician-directed medical practice.

(iii) The medical home utilizes a whole child orientation.

(iv) Care is coordinated or integrated across all of the elements of the health care system and the family and child's community.

(v) Information, education, and support to consumers and families in the program is provided in a culturally competent manner.

(vi) Quality and safety practices and measures.

(vii) Provides enhanced access to care, including access to after-hours care.

(viii) Payment is structured appropriately to recognize the added value provided to children and their families.

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

(8) Provide the department with data for quality monitoring and improvement measures, as determined necessary by the department. The department shall institute quality monitoring and improvement measures that are appropriate for children and youth with special health care needs.

(c) The services provided under these models shall not be limited to medically necessary services required to treat the CCS-eligible medical condition.

(d) Notwithstanding any other provision of law, and to the extent permitted by federal law, the department may require eligible individuals to enroll in these models.

(e) At the election of the Managed Risk Medical Insurance Board, and with the consent of the director, children enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, who are eligible for CCS under Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, may enroll in the organized health care delivery models established under this section.

(f) For the purposes of implementing this section, the department shall seek proposals to establish and test these models of organized health care delivery systems, 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 under this section. Contracts may be statewide or on a more limited geographic basis. Contracts entered into or amended under this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code.

(g) (1) Entities contracting with the department under this section shall report expenditures for the services provided under the contract.

(2) If a contractor is paid according to a capitated or risk-based payment methodology, the rates shall be actuarially sound and take into account care coordination activities.

(h) (1) The department shall conduct an evaluation to assess the effectiveness of each model in improving the delivery of health care services for children who are eligible for CCS. The department shall consult with stakeholders in developing an evaluation for the models being tested.

(2) The evaluation process shall begin simultaneously with the development and implementation of the model delivery systems to compare the care provided to, and outcomes of, children enrolled in the models with those not enrolled in the models. The evaluation shall include, at a minimum, an assessment of all of the following:

(A) The types of services and expenditures for services.

(B) Improvement in the coordination of care for children.

(C) Improvement in the quality of care.

(D) Improvement in the value of care provided.

(E) The rate of growth of expenditures.

(F) Parent satisfaction.

(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 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.

*(Added by Stats. 2010, Ch. 714, Sec. 23. (SB 208) Effective October 19, 2010.)*

**14182.3.** (a) To the extent the provisions of Article 5.2 (commencing with Section 14166) do not conflict with the provisions of this article or the Special Terms and Conditions of the new demonstration project created under this article, the provisions of Article 5.2 (commencing with Section 14166) shall continue to apply to the new demonstration project.

(b) In the event of a conflict between any provision of this article and the Special Terms and Conditions required by the federal Centers for Medicare and Medicaid Services for the approval of the demonstration project described in Section 14180, the Special Terms and Conditions shall control.

(c) (1) Under the demonstration project described in Section 14180, the state shall have priority to claim against and retain the first five hundred million dollars ($500,000,000) in federal funds using expenditures incurred under state-only programs or other programs for which the state is authorized to claim under the Special Terms and Conditions of the demonstration project or federal Medicaid law, including state-only programs that serve special populations, such as those for which state savings were recognized in the Budget Act for the 2010–11 fiscal year.

(2) Notwithstanding paragraph (1), if the director determines that the amount of base funding available under the demonstration project described in Section 14180 is less than the six hundred eighty-one million six hundred forty thousand dollars ($681,640,000) available to public hospitals under the original demonstration project, the state may reallocate an amount from the five hundred million dollars ($500,000,000) described in paragraph (1) to increase the amount of base funding under the new demonstration project to six hundred eighty one million six hundred forty thousand dollars ($681,640,000).

(3) For purposes of this section, the term “base funding” includes funding for the safety net care pool or a similar pool or fund for health coverage expansion, and for an investment, incentive, or similar pool, but shall not include funds made available to hospitals or counties for inpatient or outpatient Medi-Cal reimbursements, expansion of managed care for seniors and persons with disabilities, or other expansions of systems of care for individuals who are eligible under the Medi-Cal state plan.

(4) If the state is unable to claim the full amount of the five hundred million dollars ($500,000,000) described in paragraph (1), any portion of the amount that remains unclaimed may be reallocated to be claimed based on the certified public expenditures of the designated public hospitals.

(d) The director shall have authority to maximize available federal financial participation under the demonstration project described in Section 14180, including, but not limited to, authorizing the use of intergovernmental transfers by district hospitals that are not reimbursed under a contract negotiated pursuant to the Selective Provider Contracting Program, to fund the nonfederal share of expenditures to the extent permitted by the Special Terms and Conditions of the demonstration project.

(e) Participation in intergovernmental transfers under this section is voluntary on the part of the transferring entity for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this subdivision by means of intergovernmental transfers, the transferring entity agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to the state’s implementation of these voluntary intergovernmental transfers. This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.

(f) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

*(Amended by Stats. 2011, Ch. 86, Sec. 20. (AB 1066) Effective July 15, 2011.)*

**14182.4.** (a) To the extent authorized under a federal waiver or demonstration project described in Section 14180 that is approved by the federal Centers for Medicare and Medicaid Services, the department shall establish a program of investment, improvement, and incentive payments for designated public hospitals and, to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.155, for nondesignated public hospitals to encourage and incentivize delivery system transformation and innovation in preparation for the implementation of federal health care reform.

(b) The Public Hospital Investment, Improvement, and Incentive Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this section.

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

(d) Moneys in the fund shall be used as the source for the nonfederal share of investment, improvement, and incentive payments as authorized under a federal waiver or demonstration project to participating designated public hospitals and, to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.155, to nondesignated public hospitals, defined in subdivisions (d) and (f) of Section 14166.1 respectively, and the governmental entities with which they are affiliated, that provide the intergovernmental transfers for deposit into the fund.

(e) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by law. Moneys shall be allocated from the fund by the department and used as the nonfederal share for claiming federal funds in accordance with the Special Terms and Conditions of the waiver or demonstration project and Sections 14166.77 and 14166.155, to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.151, as applicable. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed only to the designated public hospitals and the governmental entities with which they are affiliated, and to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.155, to nondesignated public hospitals as described in subdivision (a) and the governmental entities with which they are affiliated.

(f) Participation under this section is voluntary on the part of the county or other political subdivision for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this section, the county or other political subdivision agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to implementation of this section. This section shall be implemented only to the extent federal financial participation is not jeopardized.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

*(Amended by Stats. 2012, Ch. 23, Sec. 109. (AB 1467) Effective June 27, 2012.)*

**14182.45.** (a) In consultation with the designated public hospitals, as defined in subdivision (d) of Section 14166.1, and to the extent it does not impede the ability of the designated public hospitals to meet the requirements and conditions for delivery system reform incentive payments authorized under Sections 14166.77 and 14182.4, the state may provide for milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals to create incentives for improvement activities towards, and achievement of, delivery system transformation. The milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals shall be structured in accordance with the requirements and conditions for delivery system reform incentive payments set forth in the Special Terms and Conditions and as approved by the federal Centers for Medicare and Medicaid Services. Incentive payments may be funded by voluntary intergovernmental transfers made by the designated public hospitals and nondesignated public hospitals. All incentive pool funding, including any potential private and nondesignated public hospital subpools, shall be limited to the total amount of incentive pool funding allowed for delivery system reform incentive payments as set forth in the Special Terms and Conditions.

(b) Upon federal approval of the reimbursement methodology in subdivision (b) of Section 14166.151, this section shall become inoperative.

*(Amended by Stats. 2012, Ch. 23, Sec. 110. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in subd. (b).)*

**14182.9.** Notwithstanding the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this article through all-county welfare director letters or similar instruction, 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, in implementing, interpreting, or making specific this article. 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.

*(Added by renumbering Section 14182 by Stats. 2010, Ch. 714, Sec. 19. (SB 208) Effective October 19, 2010.)*