

AMENDED IN ASSEMBLY MAY 15, 2006

AMENDED IN ASSEMBLY MAY 8, 2006

AMENDED IN ASSEMBLY MAY 1, 2006

AMENDED IN ASSEMBLY APRIL 19, 2006

CALIFORNIA LEGISLATURE—2005—06 REGULAR SESSION

ASSEMBLY BILL

No. 2979

Introduced by Assembly Member Richman

February 24, 2006

An act to add Section 14087.485 to, to add and repeal Section 14499.80 of, and to add and repeal Article 9 (commencing with Section 14499.90) of Chapter 8 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 2979, as amended, Richman. Medi-Cal: managed care.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law provides for the federal Medicare Program, pursuant to which health care benefits are provided to seniors and persons with disabilities.

This bill would require the department, in consultation with stakeholders, to develop a statewide education and outreach program specific to the needs of seniors and persons with disabilities in an

effort to promote a greater understanding of, and increased enrollment in, Medi-Cal managed care.

This bill would also, until January 1, 2013, authorize the department to implement the Medicare HMO ~~wraparound~~ *Wraparound* pilot program to enable *project* for eligible individuals in selected counties to receive a continuum of services in selected participating counties, to explore more flexible managed care models that include services authorized under the federal Medicaid Program and the federal Medicare Program, provide a coordinated system of care and benefits for individuals who are eligible for both the federal Medicare Program and the Medi-Cal program and who are receiving Medicare services and Medi-Cal HMO *Wraparound* services.

This bill would also, until January 1, 2013, authorize the department to implement the Integration Plus Community Choices plan to enable eligible individuals in selected counties to receive a continuum of services that maximizes community living.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

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

1 SECTION 1. Section 14087.485 is added to the Welfare and
2 Institutions Code, to read:
3 14087.485. The department shall, in consultation with
4 stakeholders, develop a statewide education and outreach
5 program specific to the needs of seniors and persons with
6 disabilities in an effort to promote a greater understanding of, and
7 increased enrollment in, Medi-Cal managed care. In conducting
8 outreach activities for the enrollment of special needs
9 populations into the Medi-Cal Managed Care Program, the
10 department and its contractors, as deemed applicable by the
11 department, shall work with state, local, and regional
12 organizations with the ability to target low-income seniors and
13 individuals with disabilities in the communities where they live.
14 This shall include, but not be limited to, all applicable state
15 departments that serve these individuals, regional centers,
16 seniors' organizations, local health consumer centers, and other

1 consumer-focused organizations that are engaged in providing
2 assistance to this population.

3 SEC. 2. Section 14499.80 is added to the Welfare and
4 Institutions Code, to read:

5 14499.80. (a) The department may implement ~~a~~ *the* Medicare
6 ~~HMO wraparound pilot program~~ *Wraparound pilot project* for
7 eligible individuals in selected participating counties. The pilot
8 ~~program may be conducted to explore more flexible managed~~
9 ~~care models that~~ *project may* include services authorized under
10 the federal Medicaid Program (Title XIX of the Social Security
11 Act (42 U.S.C. Sec. 1396 et seq.)) and federal Medicare Program
12 (Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et
13 seq.)). The goal for the Medicare ~~HMO wraparound~~ *Wraparound*
14 pilot project shall be to provide a coordinated system of care and
15 benefits for dual eligibles receiving Medicare services and
16 ~~Medi-Cal wraparound~~ *Medicare HMO Wraparound* services.

17 (b) For purposes of this section, the following definitions shall
18 apply:

19 (1) “Contracting entity” means ~~a Medicare HMO wraparound~~
20 ~~pilot program~~ *Medi-Cal managed care plan, as defined in*
21 *subdivision (a) of Section 14087.48*, responsible for providing, or
22 arranging and paying for the provision of, ~~integrated~~ *coordinated*
23 medical benefits to eligible persons pursuant to the requirements
24 of this section.

25 (2) “Dual eligible” means any person who is simultaneously
26 qualified for full benefits under Title XIX of the Social Security
27 Act (42 U.S.C. Sec. 1396 et seq.) and Title XVIII of the Social
28 Security Act (42 U.S.C. Sec. 1395 et seq.).

29 (3) “Eligible population” means dual eligible Medi-Cal
30 beneficiaries.

31 (c) Consistent with the provisions of this section, the director
32 ~~may establish, in consultation with the federal Centers for~~
33 ~~Medicare and Medicaid Services, may establish~~ and administer a
34 federally approved project that combines Medicare and Medi-Cal
35 medical benefits. The project established under this section shall
36 be known as Medicare ~~HMO wraparound~~ *Wraparound*. The
37 department shall take all appropriate steps to amend the state
38 plan, if necessary, to carry out this section and obtain any federal
39 waivers to allow for federal financial participation. The

1 department may implement this section only to the extent that
2 federal financial participation is available.

3 (d) To the extent that the department has resources for this
4 purpose, the director may select counties in which to implement
5 Medicare HMO—~~wraparound~~ *Wraparound* pilot projects and
6 contract with qualified contracting entities selected through the
7 department’s application process. The director shall not enter into
8 contracts with any Medicare HMO—~~wraparound~~ *Wraparound*
9 contracting entities until all necessary federal approvals are
10 obtained.

11 (e) Contracting entities may be selected to provide or arrange
12 and pay for coordinated care and services covered pursuant to
13 this section, either directly or through subcontracts.

14 (f) (1) A contracting entity pursuant to this section shall be
15 licensed by the Department of Managed Health Care. In their
16 applications to the ~~program~~ *pilot project*, those entities that are
17 licensed by the Department of Managed Health Care shall
18 provide assurance that they are in good standing with that
19 department.

20 (2) A contracting entity shall be either a Medicare Advantage
21 Plan with prescription drug coverage or a Medicare Special
22 Needs Plan, or any other designated risk-based Medicare
23 managed care plan established by the Centers for Medicare and
24 Medicaid Services, that will provide Medicare benefits, Medicare
25 prescription drug coverage, and Medi-Cal benefits.

26 (3) A contracting entity shall demonstrate the ability to
27 provide, either directly or through subcontracts, Medicare and
28 Medicaid covered services. Covered services may include, when
29 determined appropriate by the director, long-term and short-term
30 nursing facility care, excluding intermediate care facilities for the
31 developmentally disabled and adult day health care, as
32 established under law and licensed by the department. For
33 purposes of this section, “short-term nursing facility care” means
34 care in a nursing facility up to and including the month of
35 admission to a nursing facility plus one month. “Long-term
36 nursing facility care” means a nursing facility stay that exceeds
37 the month of nursing facility admission plus one month. A
38 contracting entity shall agree to provide coordination of
39 Medicare and Medi-Cal services for eligible individuals as
40 specified by the department.

1 (4) A contracting entity shall meet health plan readiness
2 criteria pursuant to Section 14087.48.

3 (g) Contracting entities shall meet all external quality review
4 standards, as outlined in Subpart E (commencing with Section
5 438.320) of Title 42 of the Code of Federal Regulations.

6 (h) All Medicare HMO ~~wraparound~~ *Wraparound* contracts
7 and amendments or change orders thereto shall be exempt from
8 Chapter 2 (commencing with Section 10290) of Part 2 of
9 Division 2 of the Public Contract Code. Further, the contracts,
10 including any contract amendment or change order, shall be
11 exempt from Part 2 (commencing with Section 10100) of
12 Division 2 of the Public Contract Code, except for Chapter 8 of
13 that part, and from the requirements of Article 4 (commencing
14 with Section 19130) of Chapter 5 of Part 2 of Division 5 of the
15 Government Code.

16 (i) Enrollment in a Medicare HMO ~~wraparound~~ *Wraparound*
17 plan under this section shall be voluntary for the eligible
18 population.

19 (j) Services covered by the California Children's Services
20 Program shall be governed in this Medi-Cal managed care
21 expansion as set forth in this section in a manner that is
22 consistent with Article 2.98 (commencing with Section 14094) of
23 Chapter 7.

24 (k) The development and negotiation of capitation rates for
25 Medicare HMO *Wraparound* contracts shall involve the analysis
26 of data specific to dual eligibles. For the purposes of developing
27 or negotiating capitation rates for payments to Medicare HMO
28 *Wraparound* plans, the director may require Medicare HMO
29 *Wraparound* plans, including existing Medi-Cal managed health
30 care plans, to submit financial and utilization data in a form and
31 substance as deemed necessary by the department.

32 (l) This section shall remain in effect only until January 1,
33 2013, and as of that date is repealed, unless a later enacted statute
34 that is chaptered on or before January 1, 2013, extends or deletes
35 that date.

36 SEC. 3. Article 9 (commencing with Section 14499.90) is
37 added to Chapter 8 of Part 3 of Division 9 of the Welfare and
38 Institutions Code, to read:

1 Article 9. Integration Plus Community Choices Plans

2
3 14499.90. (a) (1) The department may implement *the*
4 Integration Plus Community Choices ~~plans~~ *pilot project* to enable
5 individuals to receive a continuum of services that maximizes
6 community living. The ~~pilot-program~~ *project* may be conducted
7 to explore ~~more-flexible~~ managed care models that include
8 services authorized under the federal Medicaid Program (Title
9 XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and
10 the federal Medicare Program (Title XVIII of the Social Security
11 Act (42 U.S.C. Sec. 1395 et seq.)).

12 (2) Enrollment of eligible individuals under this article shall
13 be contingent on an appropriation for that purpose in the annual
14 Budget Act or another statute.

15 (3) The department shall develop an implementation plan and
16 submit the plan to the appropriate fiscal and policy committees of
17 the Legislature prior to enrolling individuals under this article.
18 The implementation plan shall meet the requirements outlined in
19 this article, and shall address the provision of quality, accessible
20 health care services under the proposed pilot projects.
21 Specifically, the implementation plan shall include plan readiness
22 standards including, but not limited to, those outlined in
23 subdivisions (m) and (o), monitoring of the contracting entity and
24 participating provider compliance with contract requirements,
25 and the rate methodology utilized to develop the capitation rates
26 paid to contracting entities. The rates shall be prepared in
27 accordance with generally accepted actuarial principles and
28 practices.

29 (b) Goals for the Integration Plus Community Choices Plans
30 shall include all of the following:

31 (1) To coordinate Medi-Cal and Medicare benefits across care
32 settings and improve continuity of acute care, long-term care, and
33 home- and community-based services.

34 (2) To coordinate access to acute and long-term care services
35 for ~~seniors and adult~~ *eligible seniors and* persons with
36 disabilities.

37 (3) To maximize the ability of ~~seniors and adult~~ *eligible*
38 *seniors and* persons with disabilities to remain in their homes and
39 communities with appropriate services and supports in lieu of
40 institutional care.

1 (4) To increase the availability of and access to home- and
2 community-based alternatives.

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

5 (1) “Contracting entity” means a Medi-Cal managed care plan,
6 as defined in subdivision (a) of Section 14087.48, responsible for
7 providing, or arranging and paying for the provision of,
8 integrated medical and home- and community-based benefits to
9 eligible persons pursuant to the requirements of this section.

10 (2) ~~“Seniors and adult”~~ *“Eligible seniors and persons with*
11 *disabilities”* means ~~individuals, 21 years of age or older, who~~
12 ~~otherwise are eligible~~ *Medi-Cal beneficiaries eligible* for benefits
13 through age, blindness, or disability, as defined in Title XVI of
14 the Social Security Act (42 U.S.C. Sec. 1381 et seq.).

15 (3) “Dual eligible” means any person who is simultaneously
16 qualified for full benefits under Title XIX of the Social Security
17 Act (42 U.S.C. Sec. 1396 et seq.) and Title XVIII of the Social
18 Security Act (42 U.S.C. Sec. 1395 et seq.).

19 (4) “Eligible population” means seniors and ~~adult~~ persons with
20 disabilities, *21 years of age or older*, who are dual eligible or
21 Medi-Cal only eligible beneficiaries.

22 (5) “Home- and community-based services” means services
23 that could be approved by the federal Centers for Medicare and
24 Medicaid Services under Section 1915(c) of the federal Social
25 Security Act. These services may include, but are not limited to,
26 the following: case management services, homemaker services,
27 personal care services, adult day health care services, habilitation
28 services, respite care services, home nursing services, personal
29 emergency response systems, and minor home modifications.

30 (d) Consistent with this article, and to the extent that the
31 department has resources for this purpose, the director may
32 ~~establish and administer, upon approval from the federal Centers~~
33 ~~for Medicare and Medicaid Services, and administer a project~~
34 *establish and administer a federally approved project* that
35 integrates Medicare and Medi-Cal medical benefits, home-and
36 community-based benefits, and financing. The pilot project
37 established under this section shall be known as Integration Plus
38 Community Choices. The department shall take all appropriate
39 steps to amend the state plan, if necessary, to carry out this
40 section and obtain any federal waivers to allow for federal

1 financial participation. This section shall be implemented only to
2 the extent that federal financial participation is available.

3 (e) Notwithstanding subparagraph (B) of paragraph (1) of
4 subdivision (c) of Section 14089, and paragraph (3) of
5 subdivision (b) of Section 53845 of, subparagraph (A) of
6 paragraph (3) of subdivision (b) of Section 53906 of, and
7 subdivision (a) of Section 53921 of, Title 22 of the California
8 Code of Regulations, the department may require that ~~seniors and~~
9 ~~adult~~ *eligible seniors and persons with disabilities* be assigned as
10 mandatory enrollees into Integration Plus Community Choices
11 health plans authorized by this article in up to two counties. One
12 of the counties shall be a county that provides Medi-Cal managed
13 care services under the Two-Plan Model pursuant to Article 2.8
14 (commencing with Section 14087.3) of Chapter 7. The other
15 county shall be a county that provides Medi-Cal managed care
16 services under the County Organized Health Systems model
17 pursuant to Article 2.7 (commencing with Section 14087.5) of
18 Chapter 7. The director may contract with qualified contracting
19 entities to implement the Integration Plus Community Choices
20 pilot project. The director shall not enter into contracts with any
21 Integration Plus Community Choices contracting entities until all
22 necessary federal approvals are obtained.

23 (f) To be selected to participate in the Integration Plus
24 Community Choices pilot project, any two-plan or county
25 organized health system county must demonstrate each of the
26 following:

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

29 (2) Sufficient home- and community-based services that can
30 serve ~~seniors and adult~~ *eligible seniors and persons with*
31 *disabilities* in the pilot project.

32 (3) A stakeholder process that includes health plans, providers,
33 community programs, consumers, and other interested
34 stakeholders in the development, implementation, and continued
35 operation of the pilot project.

36 (4) An appropriate provider network within the service area,
37 including a sufficient number of provider types necessary to
38 furnish comprehensive services to ~~seniors and adult~~ *eligible*
39 *seniors and persons with disabilities*.

1 (g) Contracting entities shall be selected to provide or arrange
2 and pay for comprehensive medical and home- and
3 community-based services that integrate components of care and
4 services covered pursuant to this section, either directly or
5 through subcontracts.

6 (h) (1) A contracting entity pursuant to this section shall be
7 licensed by the Department of Managed Health Care under the
8 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
9 (commencing with Section 1340) of Division 2 of the Health and
10 Safety Code) and in good standing with that department.

11 (2) A contracting entity shall be either a Medicare Advantage
12 plan with prescription drug coverage or a Medicare Special
13 Needs Plan, or any other such designated risk-based Medicare
14 managed care plan established by the Centers for Medicare and
15 Medicaid Services that will offer Medicare benefits and
16 Medicare prescription drug coverage as well as Medi-Cal
17 medical and home- and community-based services.

18 (3) A contracting entity shall demonstrate an ability to
19 provide, either directly or through subcontracts, Medicare and
20 Medicaid covered services. Contracts between the department
21 and the contracting entities shall set forth the scope of Medi-Cal
22 medical and home- and community-based benefits, appropriate
23 standards for serving the enrolled population, standards for
24 home- and community-based provider networks, and quality
25 standards developed by the department and approved by the
26 federal Centers for Medicare and Medicaid Services.

27 (i) Contracting entities pursuant to this section shall be
28 required to provide services that include, but are not limited to,
29 the following:

30 (1) A care management system that considers an individual's
31 needs and preferences across medical, social, and supportive
32 services. The care management system shall include:

33 (A) Services provided by individuals trained in serving the
34 needs of *eligible* seniors and persons with disabilities across the
35 acute and long-term care continuum.

36 (B) Services provided in a culturally and linguistically
37 appropriate manner, involving the member and the member's
38 formal and informal support networks, thereby empowering the
39 consumer and taking into consideration his or her values,
40 lifestyle, and culture.

- 1 (C) Services that assist the member to navigate treatment
2 settings, including home, hospital, and nursing facility.
- 3 (D) Levels of care management services based on the unique
4 needs of each Integration Plus Community Choices member.
- 5 (E) Person-centered care and service planning that provides an
6 assessment of needs and preferences and an individual care plan
7 based on the unique needs of each member.
- 8 (F) Procedures that ensure that the member has the
9 opportunity to participate in the care planning process to the
10 fullest extent of his or her capacity.
- 11 (G) Care-planning that maximizes independence, home- and
12 community-based services, and diversion from institutional care.
- 13 (2) A comprehensive scope of benefits that includes all of the
14 following:
- 15 (A) Long-term and short-term nursing facility care, excluding
16 intermediate care facilities for the developmentally disabled.
- 17 (B) Adult day health care, as established under law and
18 licensed by the department.
- 19 (C) Home- and community-based services.
- 20 (D) Full scope of Medi-Cal benefits except for services
21 authorized and provided by regional centers, as described in
22 subdivision (q), and those coordinated services as specified in
23 paragraph (3) of subdivision (i) and the In Home Supportive
24 Services Program.
- 25 (E) Medicare benefits, including Part A, Part B, and Part D,
26 for those enrollees who are Medicare-eligible.
- 27 (3) A system to coordinate with services not covered under the
28 Integration Plus Community Choices plan, including:
- 29 (A) The In-Home Supportive Services (IHSS) program.
- 30 (B) Services authorized by regional centers as specified in
31 subdivision-~~(o)~~ (q), for those who are eligible for regional center
32 services.
- 33 (C) County specialty mental health services for those who are
34 eligible.
- 35 (D) Independent Living Center services for those who are
36 eligible.
- 37 (E) Older Americans Act and Older Californians Act services
38 and supports.
- 39 (j) (1) Within 60 days of entering into a contract with the
40 department, a contracting entity and local mental health plans in

1 the contracting entity's contracting service area shall execute a
2 memorandum of understanding for the coordination of services
3 for members of the managed care health plan who need specialty
4 mental health services. The State Department of Health Services
5 and the State Department of Mental Health, in consultation with
6 the California Mental Health Director's Association, shall jointly
7 prepare a model memorandum of understanding to be used by
8 contracting entities and local mental health plans to comply with
9 this section. The memorandum of understanding shall include a
10 provision for the Integration Plus Community Choices plan and
11 the county specialty mental health plan to coordinate medical,
12 pharmaceutical, and long-term care services with any county
13 specialty mental health services for which Integration Plus
14 Community Choices plan members are eligible.

15 (2) Within 60 days of entering into a contract with the
16 department, a contracting entity and the local regional centers in
17 the contracting entity's contracting service area shall execute a
18 memorandum of understanding for the coordination of services
19 for members of the managed care health plan with developmental
20 disabilities. The State Department of Health Services and the
21 State Department of Developmental Services shall jointly prepare
22 a model memorandum of understanding to be used by contracting
23 entities and local regional centers to comply with this section.

24 (k) Contracting entities shall meet all external quality review
25 standards, as outlined in Subpart E (commencing with Section
26 438.320) of Title 42 of the Code of Federal Regulations.

27 (l) The department shall, throughout the term of the project,
28 consult with and seek input from stakeholders including, but not
29 limited to, current and potential consumers of home- and
30 community-based services, formal and informal caregivers,
31 advocacy organizations representing *eligible* seniors and persons
32 with disabilities, health plans, service providers, and any
33 stakeholder advisory committee established to provide input to
34 the agency regarding the United State Supreme Court decision in
35 *Olmstead v. L.C.* consistent with Title II of the Americans with
36 Disabilities Act.

37 (m) The department shall, in consultation with stakeholders, as
38 specified in subdivision (l), develop policy, quality of care,
39 continuity of care, and performance standards and measures
40 specific to the Integration Plus Community Choices plan. Quality

1 of care and performance standards shall include, at a minimum,
2 all of the following:

3 (1) Existing statutory and regulatory requirements specific to
4 two-plan model and county organized health system plans.

5 (2) Requirements and standards specific to the complex care
6 needs of *eligible* seniors and persons with disabilities.

7 (3) Care planning standards that support members as they seek
8 services and supports in the most integrated community settings.

9 (n) Prior to implementation of Integration Plus Community
10 Choices, the department shall do the following:

11 (1) Implement an appropriate awareness and sensitivity
12 training program for all staff in the Office of the Medi-Cal
13 Managed Care Ombudsman.

14 (2) Coordinate with Medi-Cal managed care health plans
15 selected for the pilot ~~program~~ *project* to develop and implement
16 a mutually acceptable mechanism to identify, within the earliest
17 ~~possible timeframe, persons with special health care needs,~~
18 ~~particularly seniors and persons with disabilities.~~ *possible*
19 *timeframe, eligible seniors and persons with disabilities who*
20 *have special health care needs.*

21 (3) Provide Medi-Cal managed care health plans involved in
22 the pilot ~~program~~ *project* with a list containing the names of
23 fee-for-service providers that are providing services to
24 beneficiaries who are to be enrolled in a managed care health
25 plan so Medi-Cal managed health care plans involved in the pilot
26 ~~program~~ *project* may use this data to assist beneficiaries in
27 continuing their existing provider-patient relationships.

28 (4) Develop and provide Medi-Cal managed care health plans
29 selected for the pilot ~~program~~ *project* with a checklist for use in
30 meeting the requirements of the Americans with Disabilities Act.

31 (5) Participate in a stakeholder process in those counties
32 designated for the pilot ~~program~~ *project* at least four months
33 prior to the enrollment of *eligible* seniors and persons with
34 disabilities. Stakeholders may include, but will not be limited to,
35 persons with disabilities, seniors, Medi-Cal managed care health
36 plans, physicians, hospitals, consumer advocates, disability
37 advocates, county or University of California hospitals, and
38 exclusive collective bargaining agents for hospital workers of
39 affected hospitals.

- 1 (6) Have a process to enforce all legal sanctions, including, but
2 not limited to, financial penalties, withholds, enrollment
3 termination, and contract termination, in order to sanction any
4 Medi-Cal managed care health plan involved in the pilot-program
5 *project* that fails to meet performance standards.
- 6 (7) Require that all Medi-Cal managed care plans involved in
7 the pilot-program *project* submit all required contract
8 deliverables and have demonstrated that they have satisfactorily
9 met department standards.
- 10 (8) Require that the primary services for the pilot-programs
11 *project* include access to reproductive services, including
12 procedures for providing female seniors and females with
13 disabilities with direct access to an obstetrician-gynecologist to
14 provide women’s routine and preventive health care services, and
15 that ensure that pregnant women with disabilities at a high risk of
16 poor pregnancy outcome for the mother or the child are referred
17 to appropriate specialists, including perinatologists, and have
18 access to genetic screening with appropriate referrals.
- 19 (9) Ensure that the pilot-program *project* provides an
20 opportunity for members to select a specialist as a primary care
21 provider as defined in subdivision (ff) of Section 53810 of Title
22 22 of the California Code of Regulations.
- 23 (10) Ensure that the pilot-program *project* makes reasonable
24 efforts to provide *eligible* seniors and persons with disabilities
25 with access to the following services:
- 26 (A) Inpatient and outpatient rehabilitation services through
27 providers accredited by the Commission on Accreditation of
28 Rehabilitation Facilities (CARF), or other similar accreditation
29 organization.
- 30 (B) Applied rehabilitative technology.
- 31 (C) Speech pathologists, including those experienced in
32 working with significant speech impairment, persons with
33 developmental disabilities, and persons who require
34 augmentative communication devices.
- 35 (D) Occupational therapy, orthotic providers.
- 36 (E) Physical therapy.
- 37 (F) Low-vision centers.
- 38 (G) Other services with expertise in working with *eligible*
39 seniors and persons with disabilities.

1 (11) Ensure that Medi-Cal managed care health plans involved
2 in the pilot program provide access to assessments and
3 evaluations for wheelchairs that are independent of durable
4 medical equipment providers and include, when necessary, a
5 home assessment.

6 (12) Ensure that Medi-Cal managed care health plans involved
7 in the pilot ~~program~~ *project* are able to provide communication
8 access to *eligible* seniors and persons with disabilities in
9 alternative formats or through other methods that assure
10 communication, including assistive listening systems, sign
11 language interpreters, captioning, pad and pencil, or written
12 translations and oral interpreters, including for those who are
13 limited English proficient, and that all such Medi-Cal managed
14 care health plans are in compliance with the cultural and
15 linguistic requirements set forth in subdivision (c) of Section
16 53853 and Section 53876 of Title 22 of the California Code of
17 Regulations.

18 (13) Ensure that Medi-Cal managed care health plans involved
19 in the pilot ~~program~~ *project* provide access to out-of-network
20 providers for individual seniors and persons with disabilities
21 members who have an ongoing relationship with such a provider,
22 if the provider will accept the rates offered by the plan, and the
23 plan determines that the provider meets applicable professional
24 standards and has no disqualifying quality of care issues.

25 (o) Critical health plan readiness criteria shall include, but not
26 be limited to, the requirements pursuant to paragraphs (1) to (8),
27 inclusive, of subdivision (b) of Section 14087.48 and all of the
28 following:

29 (1) Collection, review, and approval of contract deliverables,
30 such as Knox-Keene licenses, policies and procedures, and
31 provider sites.

32 (2) Information technology systems.

33 (3) Transition plan protocol to ensure continuity of care for
34 consumers.

35 (4) Creation and distribution of beneficiary and provider
36 information and enrollment materials and processes.

37 (5) Availability of consumer information on the Internet, in
38 person or by mail, in languages and formats that are accessible,
39 including those formats used by individuals who are visually and
40 hearing impaired.

1 (6) Establishment of an appropriate provider network,
2 including primary care physicians, specialists, professional,
3 allied, and medical supportive personnel, and an adequate
4 number of facilities within each service area.

5 (7) *Availability of provider network information that meets the*
6 *linguistic and other special needs of eligible seniors and persons*
7 *with disabilities, including printed materials that provide*
8 *information in an understandable manner, toll-free telephone*
9 *lines, and member or ombudsman services.*

10 ~~(7)~~

11 (8) Ability to assess the health care needs of ~~beneficiaries who~~
12 ~~are~~ *eligible* seniors and persons with disabilities and coordinate
13 their care across all settings, including coordination of discharge
14 to necessary services within and, where necessary, outside of the
15 plan's provider network.

16 ~~(8)~~

17 (9) Compliance with relevant federal and state statutes and
18 regulations to ensure access for *eligible* seniors and persons with
19 disabilities.

20 ~~(9)~~

21 (10) Ability to ensure timely access, and where appropriate,
22 standing referrals to specialists within or, where necessary,
23 outside of the plan's provider network, including ~~pediatric~~
24 ~~specialists~~, subspecialists, speciality care centers, ancillary
25 therapists, and specialized equipment and supplies, including
26 durable medical equipment.

27 ~~(10)~~

28 (11) Ability to provide clear, timely, and fair processes for
29 accepting and acting upon complaints, grievances, and
30 disenrollment requests, including procedures for appealing
31 decisions regarding coverage or benefits. Each plan involved in
32 the pilot ~~program~~ *project* shall have a grievance process that
33 complies with Sections 1368 and 1368.01 of the Health and
34 Safety Code.

35 ~~(11)~~

36 (12) A process for stakeholder and member participation in
37 advisory groups for the planning and development activities
38 related to provision of services for *eligible* seniors and persons
39 with disabilities.

40 ~~(12)~~

1 (13) Established contracts with traditional and safety net
 2 providers to ensure access to care and services.

3 ~~(13)~~

4 (14) Available information for *eligible* seniors and persons
 5 with disabilities of procedures for obtaining transportation
 6 services to service sites that are offered by the plan or are
 7 available through the Medi-Cal program.

8 ~~(14)~~

9 (15) Capacity to monitor and improve the quality and
 10 appropriateness of care for ~~and seniors and adult~~ *eligible seniors*
 11 *and* persons with disabilities.

12 (p) All Integration Plus Community Choices Plan contracts
 13 and amendments or change orders thereto shall be exempt from
 14 the provisions of Chapter 2 (commencing with Section 10290) of
 15 Part 2 of Division 2 of the Public Contract Code. Further, these
 16 contracts, including any contract amendment or change order,
 17 shall be exempt from Part 2 (commencing with Section 10100) of
 18 Division 2 of the Public Contract Code, and from the
 19 requirements of Article 4 (commencing with Section 19130) of
 20 Chapter 5 of Part 2 of Division 5 of the Government Code.

21 (q) The Integration Plus Community Choices project shall not
 22 include or affect services and supports provided by regional
 23 centers established pursuant to Chapter 5 (commencing with
 24 Section 4620) of Division 4.5, including, but not limited to, the
 25 following:

26 (1) Targeted Case Management State Plan Amendment under
 27 Sections 1905(a)(19) (42 U.S.C. Sec. 1396d(a)(19)) and
 28 1915(g)(2) of the federal Social Security Act (42 U.S.C. Sec.
 29 1396n(g)).

30 (2) Section 1915(c) Home- and Community-based Services
 31 Waivers, Section 1915(c) of the federal Social Security Act (42
 32 U.S.C. Sec. 1396n(c)).

33 (3) Early Intervention Services for children under four years of
 34 age, provided for under Title 14 (commencing with Section
 35 95000) of the Government Code and under Part C of the federal
 36 Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400
 37 et seq.).

38 (4) Pre-Assessment, Screening-Resident Review, Nursing
 39 Home Reform under Section 1919(F) of the federal Social
 40 Security Act (42 U.S.C. Sec. 1396r).

1 (5) Any service and support provided by regional centers
2 solely to active recipients of regional center services, but only for
3 services that do not supplant the budget of any agency that has a
4 legal responsibility to serve all members of the general public
5 and is receiving public funds for providing those services under
6 Section 4648, and for services for which regional centers are
7 responsible for pursuing funding as defined in subdivision (a) of
8 Section 4659.

9 (r) In pilot counties where the Program of All-Inclusive Care
10 for the Elderly (PACE) is available, eligible individuals shall
11 continue to have the option of enrolling in PACE plans rather
12 than the Integration Plus Community Choices plan.

13 (s) The development and negotiation of capitation rates for
14 Integration Plus Community Choices contracts shall involve the
15 analysis of data specific to the eligible population. For the
16 purposes of developing or negotiating capitation rates for
17 payments to Integration Plus Community Choices plans, the
18 director may require Integration Plus Community Choices plans,
19 including existing Medi-Cal managed care health plans, to
20 submit financial and utilization data in a form and substance as
21 deemed necessary by the department.

22 (t) This article shall remain in effect only until January 1,
23 2013, and as of that date is repealed, unless a later enacted statute
24 that is chaptered on or before January 1, 2013, extends or deletes
25 that date.

26 SEC. 4. (a) The State Department of Health Services shall
27 ~~develop an evaluation methodology~~ *conduct an evaluation* to
28 assess outcomes and the experience of seniors and persons with
29 disabilities in the Medicare HMO Wraparound and Integration
30 Plus Community Choices pilot projects. The evaluation shall be
31 initiated by January 2012. Evaluation components shall include,
32 but are not limited to:

33 (1) Cost Effectiveness: Compare costs for those who remain in
34 fee-for-service to those who enroll in pilot plans.

35 (2) Carve Outs: Assess the impact on utilization of services,
36 the population, and costs.

37 (3) Adverse Selection: Determine if there is a trend for
38 beneficiaries enrolling or disenrolling when they first begin to
39 use long-term care services. Determine the number of long-term
40 care institutional days for enrolled recipients compared to those

1 in fee-for-service and to those in health plans that do not include
2 the long-term care institutional benefit.

3 (4) Quality of Care: Assess participant satisfaction with
4 quality of care and services after enrollment in pilot projects.

5 (b) The department shall provide briefings to the Legislature
6 in April 2008, 2009, 2010, 2011, and 2012 on the progress of the
7 Medicare HMO Wraparound and Integration Plus Community
8 Choices pilot projects.

9 (c) The department shall complete development of policy and
10 project standards and requirements, in consultation with
11 stakeholders, no later than January 2007.

12 SEC. 5. This act is an urgency statute necessary for the
13 immediate preservation of the public peace, health, or safety
14 within the meaning of Article IV of the Constitution and shall go
15 into immediate effect. The facts constituting the necessity are:

16 In order to make the necessary statutory changes to implement
17 the Budget Act of 2006 at the earliest possible time, it is
18 necessary that this act take effect immediately.