AMENDED IN SENATE AUGUST 2, 2010

AMENDED IN SENATE JUNE 23, 2010

AMENDED IN ASSEMBLY MAY 18, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 342

Introduced by Assembly Member John A. Pérez
(Coauthor: Assembly Member Monning)
(Coauthor: Senator Steinberg)

February 18, 2009

An act to amend Section 15908 of, *amend and renumber and add Section 14182 of,* to add Sections 14132.275, ~~14183, 14183.1, 14183.5, 14184~~ *14182.1, 14182.15, and 14182.2* to, and to add Part 3.6 (commencing with Section 15909) to 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 342, as amended, John A. Pérez. Medi-Cal: demonstration project waivers.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing federal law provides for the federal Medicare Program, which is a public health insurance program for persons 65 years of age and

older and specified persons with disabilities who are under 65 years of age.

This bill would, to the extent that federal financial participation is available, and pursuant to a demonstration project or waiver of federal law, require the department to establish pilot projects in up to 4 counties, as specified, to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs. This bill would require the department to, no later than ~~January 1, 2012,~~ *April 1, 2011,* identify health care models that may be included in a pilot project ~~and~~, to develop a timeline and process for selecting, financing, monitoring, and evaluating the pilot projects, *and to provide this timeline and process to certain committees of the Legislature*.

Existing law requires the department to seek a demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors and persons with disabilities and children with special health care needs.

This bill would, in furtherance of the *waiver or* demonstration project and to the extent that federal financial participation is available, permit the department to ~~develop a pilot project that would~~ require seniors and persons with disabilities *who do not have other health coverage* to be assigned as mandatory enrollees into new and existing managed care health plans or county alternative models of care, as specified. This bill would provide that enrollment of seniors and persons with disabilities shall be accomplished using a phased-in process and shall not commence until necessary federal approvals have been acquired, or until February 1, 2011, whichever is later. The bill would impose various requirements upon managed care health plans and county alternative models of care participating in the demonstration program.

This bill would, ~~commencing January 1, 2011, require all Medi-Cal managed care health plans and other managed care arrangements, as specified, to submit data, including encounter data and financial data, for the development of rates, monitoring performance, and ensuring quality.~~ *beginning January 1, 2012, require managed care health plans and county alternative models of care to comply with quality submission standards developed by the department as prescribed.*

This bill would require the department, in conjunction with the implementation of the pilot project, to work with counties to develop a method to be used in determining the appropriate contribution to cover

the nonfederal share of inpatient hospital expenses for seniors and persons with disabilities in the Medi-Cal program.

Existing law, the Robert W. Crown California Children's Services Act, requires the department and each county to administer the California Children Services (CCS) program for treatment services for persons under 21 years of age diagnosed with severe chronic disease or severe physical limitations, as specified.

This bill also would, in furtherance of the *waiver or* demonstration project, require the Director of Health Care Services to establish, by January 1, 2012, models of organized health care delivery systems, as specified, for children eligible for services under the CCS program. This bill would provide that, to the extent permitted by federal law, the department may require eligible individuals to enroll in these models. This bill would also permit the Managed Risk Medical Insurance Board to elect, with the consent of the director, to permit children enrolled in the Healthy Families Program who are eligible for CCS services to enroll in these organized health care delivery models.

Existing law provides for the Health Care Coverage Initiative, which is a federal waiver demonstration project established to expand health care coverage to low-income uninsured individuals who are not currently eligible for the Medi-Cal program, the Healthy Families Program, or the Access for Infants and Mothers program.

Existing law provides for the repeal of ~~this~~ *the department's* authority *under the Health Care Coverage Initiative* upon the execution of a declaration by the Director of Health Care Services specifying that the demonstration project has been terminated.

This bill would, alternatively, authorize the director to execute a declaration continuing the demonstration project to the extent authorized by a successor federal waiver or demonstration project.

This bill would, in this regard, *only* to the extent that federal financial participation is available *and only to the extent that federal financial participation is not jeopardized*, require the department to, on or after September 1, 2010, but no later than January 1, 2011, or 180 days after federal approval ~~is obtained, seek~~ *of* a successor demonstration project or federal waiver of Medicaid law to ~~establish~~ *authorize local* Coverage Expansion and Enrollment Demonstration (CEED) projects, as specified, to provide scheduled health care benefits for uninsured adults 19 to 64, inclusive, years of age with incomes up to 200% of the federal poverty level who are not otherwise eligible for Medi-Cal or Medicare. This bill would require CEED projects to be designed and implemented with

the systems and program elements necessary to facilitate the transition of those eligible individuals to the Medi-Cal program, or alternatively, to coverage through the state health insurance exchange, by 2014, pursuant to the provisions of federal and state law, and the terms and conditions of specified successor federal waivers or demonstrations projects.

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

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 14132.275 is added to the Welfare and Institutions Code, to read:

14132.275. (a) The department shall seek federal approval to establish pilot projects described in this section pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination thereof. Under a Medicare demonstration, the department may operate the Medicare component of a pilot project as a delegated Medicare benefit administrator, and may enter into financing arrangements with the federal Centers for Medicare and Medicaid Services to share in any Medicare program savings generated by the operation of any pilot project.

(b) After federal approval is obtained, the department shall establish pilot projects that enable dual eligibles to receive a continuum of services, and that maximize the coordination of benefits between the Medi-Cal and Medicare programs and access to the continuum of services needed. The purpose of the pilot projects is to develop effective health care models that integrate services authorized under the federal Medicaid Program (Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)). These pilot projects may also include additional services as approved through a demonstration project or waiver, or a combination thereof.

(c) No later than ~~January 1, 2012~~ *April 1, 2011*, the department shall identify health care models that may be included in a pilot project, ~~and~~ shall develop a timeline and process for selecting, financing, monitoring, and evaluating these pilot ~~projects.~~ *projects,*

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

(d) Goals for the pilot projects shall include all of the following:

(1) Coordinating Medi-Cal ~~and Medicare benefits~~ *benefits, Medicare benefits, or both,* across health care settings and improving continuity of acute care, long-term care, and home- and community-based services.

(2) Coordinating access to acute and long-term care services for dual eligibles.

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

(4) Increasing the availability of and access to home- and community-based alternatives.

(e) Pilot projects shall be established in up to four counties, and shall include at least one county that provides Medi-Cal services via a two-plan model pursuant to Article 2.7 (commencing with Section 14087.3) and *at least* one county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5). In determining the counties in which to establish a pilot project, the director shall consider the following:

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

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

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

(g) Notwithstanding any other provision of state law, the department may require that dual eligibles be assigned as mandatory enrollees into managed care plans established or

expanded as part of a pilot project. To the extent that mandatory enrollment is required, except for subdivision (f) of Section ~~14183~~ *14182*, any requirement of the department and the health plans, and any requirement of continuity of care protections for enrollees, as specified in Section ~~14183~~ *14182*, shall be applicable to this section. Dual eligibles shall have the option to forgo receiving Medicare benefits under a pilot project. *Nothing in this section shall be interpreted to reduce benefits otherwise available under the Medi-Cal program or the Medicare Program.*

(h) For purposes of this section, a "dual eligible" means an individual who is simultaneously eligible for full scope benefits under Medi-Cal and the federal Medicare program.

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

(j) ~~The~~ *Notwithstanding Section 10231.5 of the Government Code, the* department shall conduct an evaluation to assess outcomes and the experience of dual eligibles in these pilot projects and shall provide a report to the Legislature after the first full year of pilot operation, and annually thereafter. *A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code. The department shall convene a stakeholder technical workgroup to advise on the scope and structure of the evaluation.*

(k) This section shall be implemented only if and to the extent that federal financial participation or funding is available to establish these pilot projects.

(*l*) 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.

SEC. 2. Section 14182 of the Welfare and Institutions Code is amended and renumbered to read:

~~14182.~~

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.

~~SEC. 2.~~

SEC. 3. Section ~~14183~~ *14182* is added to the Welfare and Institutions Code, to read:

~~14183.~~

14182. (a) ~~In furtherance of the~~ *(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, or county alternative models of care as described in subdivision (f). 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 ~~provider~~ *health plan* or county alternative model of care.

(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 or county alternative models of care to address the unique needs of seniors or persons with disabilities pursuant to the

applicable readiness evaluation criteria and requirements set ~~for~~ *forth* in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure the managed care health plans or county alternative models of care *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 county alternative models of care, 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 plan or county alternative model of care. 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.

~~(6)~~

(7) Coordinate with the managed care health plans and county alternative models of care, in consultation with stakeholders and consumers, to develop and implement a mechanism or algorithm to identify, within the earliest possible timeframe, persons with ~~the highest risk and most~~ *higher risk and more* complex health care needs.

~~(7)~~

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

~~(8)~~

(9) Develop and provide managed care health plans and county alternative models of care participating in the demonstration project with ~~an enhanced~~ *a* facility site review tool for use in assessing the physical accessibility of providers, including specialists and ancillary service ~~providers,~~ *providers that provide care to a high volume of seniors and persons with disabilities,* at a clinic or provider site, ~~in order~~ to ensure that there are sufficient physically accessible providers.

~~(9)~~

(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 or county alternative models of care in the demonstration project that consistently or repeatedly fails to meet performance standards.

~~(10)~~

(11) Ensure that managed care health plans and county alternative models of care 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.*

~~(11)~~

(12) Ensure that managed care health plans and county alternative models of care 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, pad and pencil, 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 and county alternative models are in compliance with applicable cultural and linguistic requirements.

~~(12)~~

(13) Ensure that managed care health plans and county alternative models 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 or the county alternative model of care's rate for the service offered, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the health plan or county alternative model of care determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

~~(13)~~

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

~~(14)~~

(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 and county alternative models of care 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 provide quality indicators for the Medi-Cal population enrolled in a managed care health plan or county alternative model of care and for the subset of enrollees who are seniors and persons with disabilities. These performance measures may include Healthcare Effectiveness Data and Information Set (HEDIS) measures.

(18) Conduct medical audit reviews of participating managed care health plans and county alternative models of care that include elements specifically related to the care of seniors and persons with disabilities. These medical audits shall include evaluation of the delivery model's policies and procedures.

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

(c) Prior to exercising its authority under this section and Section 14180, the department shall ensure that each managed care health plan or county alternative model of care 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. The assessment of network adequacy shall be determined in collaboration with the Department of Managed Health Care.

(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. Health plans and county alternative models shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and

made available to enrollees, at a minimum, by phone, written material, or 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 plan participating in the demonstration project shall have a grievance process that complies with 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 or county alternative model of care shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

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

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

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

~~(11) Stratify incoming beneficiaries with aide codes applicable to seniors and persons with disabilities of high or low risk by applying a risk stratification algorithm approved by the department to member specific fee-for-service claims data provided to the managed care health plan or county alternative model of care at the time of enrollment of the beneficiary.~~

~~(12) (A) Administer a risk assessment survey tool approved by the department to determine risk level of enrollees, which shall be utilized by managed care health plans and county alternative models of care participating under the demonstration project. Managed care health plans and county alternative models of care shall perform a telephonic assessment of newly enrolled beneficiaries based on their risk as determined by the risk stratification algorithm specified in paragraph (11) within the~~

(11) Offer a contract or subcontract to an entity licensed as a primary care clinic pursuant to subdivision (a) of Section 1204 of the Health and Safety Code. The department shall ensure that managed care contracts and subcontracts with primary care clinics are on the same terms and conditions, including, but not limited to, compensation rates, as those contracts and subcontracts offered to other entities providing a similar scope of services in furtherance of the demonstration project.

(12) 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.

(13) (A) Managed health care plans and county alternative models of care 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 ~~higher risk beneficiaries~~ *individuals determined to be at higher risk pursuant to paragraph (12).*

(ii) Within 105 days of plan enrollment for ~~lower risk beneficiaries~~ *individuals determined to be at lower risk pursuant to paragraph (12).*

(B) Based on the results of the ~~telephonic~~ *current* health risk assessment, managed care health plans and county alternative models of care shall develop individual care plans for higher risk

beneficiaries that shall include the following minimum components:

(i) Redetermination of risk level if indicated.

(ii) 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.

(iii) 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 or county alternative model of care.

(iv) Appropriate involvement of caregivers.

(v) Determination of timeframes for recontact or reassessment.

~~(13)~~

(14) Establish medical homes to which enrollees are assigned that include at a minimum all of the following elements:

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

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

(C) Identification of the beneficiary's needs and referral to community resources and other agencies for services or items outside the scope of responsibility of the managed care health plan or county alternative model of care.

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

(E) Ensuring appropriate timeframes at the site and alternatives for the beneficiary's access to care for preventive, acute or chronic illness treatment as needed.

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

~~(14)~~

(15) 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 ~~the new enrollees~~ *each new enrollee's* risk level and health needs ~~through a standardized, telephonic health risk assessment to determine risk level.~~ *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 for 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 and county alternative models of care 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) Beneficiaries enrolled in managed care health plans or county alternative models of care pursuant to this section shall have the choice to continue an established patient-provider relationship in a managed care health plan or county alternative model of care 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 or county alternative model of care and agrees to continue to treat that beneficiary. *If a managed care health plan or county alternative model of care assigns beneficiaries to a federally qualified health center, the provisions of subdivision (b) of Section 14087.325 shall apply.*

(e) The department, or as applicable, the California Medical Assistance Commission, may contract with existing managed care health plans operating under the demonstration project to provide or arrange for services under this section. Notwithstanding any other provision of law, the department, or as applicable, the commission, 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. Alternatively, and notwithstanding any provision of law to the contrary, the department, or as applicable, the commission, may seek applications and thereafter contract with

any qualified individual, entity, or organization to provide or arrange for services under this section.

(f) (1) Except for counties operating under the county organized health systems model, and notwithstanding any requirements specified in Article 2.7 (commencing with Section 14087.3) and Article 2.91 (commencing with Section 14089), a county shall have the option, subject to approval by the department, to develop an alternative model of care consistent with the terms of the demonstration project to provide health care services within the scope of the county's contract with the department to beneficiaries categorized as seniors or persons with disabilities under the demonstration project. The county alternative model of care may be managed by county staff and shall not be required to obtain licensure 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), unless the model is a capitated model that assumes full risk for its beneficiaries.

(2) For purposes of this subdivision, county alternative models of care may include, at the discretion of the department, administrative services organizations, primary care case management plan, outpatient managed care models, and other models the department determines acceptable.

(3) A county shall be required to select the county alternative model of care option prior to commencement of mandatory enrollment of seniors or persons with disabilities in a county pursuant to subdivision (a), but no later than January 1, 2012.

(4) The department shall determine an actuarially sound rate for the county alternative models of care that is adequate and sufficient to ensure access to services, and that is budget neutral to the state.

(5) The department shall ensure that local county alternative option programs shall offer a contract or subcontract to an entity licensed as a primary care clinic pursuant to subdivision (a) of Section 1204 of the Health and Safety Code. The department shall ensure that contracts and subcontracts with primary care clinics are on the same terms and conditions, including, but not limited to, compensation rates, as those contracts and subcontracts offered to other noncounty entities providing a similar scope of services in furtherance of a county alternative option.

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

(h) The development and negotiation 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 or negotiating capitation rates for payments to managed care health plans, the director may require managed care health plans, including existing managed health care plans, to submit financial and utilization data in a form, time, and substance as deemed necessary by the department.

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

(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.

~~(j)~~

(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.

~~(k)~~

(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 managed care health plan 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.

~~(l)~~

(m) In the event of a conflict between the terms and conditions of the approved demonstration project, including any attachment thereto, and any provision of this part, the 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.*

~~(m)~~

(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.

~~(n)~~

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

~~(o)~~

(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.

~~(p)~~

(q) Enrollment of seniors and persons with disabilities into a managed care health plan or county alternative model of care 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 February 1, 2011, whichever is later.

~~(q)~~

(r) A managed care health plan or county alternative model of care established pursuant to this section, or under the 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 ~~14183.1~~ *14182.1*.

~~(r)~~

(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 or county alternative models of care pursuant to the pilot program. The semiannual updates shall include key milestones, progress towards 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 or county alternative models of care. The department ~~may~~ *shall* also include updates on the transition of individuals into managed care health plans and county alternative models of care, 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.

~~(s)~~

(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.

~~(t)~~

(u) The department, in cooperation with the Department of Managed Health Care, shall, at a minimum, monitor on a quarterly

basis the adequacy of provider networks of the managed care health plans or county alternative models of care.

~~(u)~~

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

~~SEC. 3.~~

SEC. 4. Section ~~14183.1~~ *14182.1* is added to the Welfare and Institutions Code, to read:

~~14183.1. (a) Commencing January 1, 2011, all managed care health plans and other managed care arrangements, including county alternative models of care developed pursuant to Section 14183, as the department shall specify, shall be required to submit data, including, but not limited to, encounter data and financial data, in the form of and to the specifications prescribed by the department for the development of rates, monitoring plan performance, and ensuring quality.~~

~~(b) Failure of a managed care health plan or other managed care arrangement to comply with the requirements established by the department under this section shall result in a penalty, imposed by the department monthly, of 2 percent of the total monthly capitation rate for that plan or arrangement per month until the plan or arrangement has fully complied with the requirements.~~

~~(c) The requirements for reporting data, pursuant to subdivision (a), shall apply to all services provided to members under this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14500), regardless of whether or not the member is a senior or a person with a disability or disabilities.~~

~~(d) Failure of a provider or subcontractor to submit data to a managed care health plan or arrangement shall not relieve the plan or arrangement from its responsibilities under this section and shall not affect imposition of the penalty as described in subdivision (b).~~

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 and county alternative models of care 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 or county alternative model of care fails to submit data in compliance with these standards. The penalty shall be in proportion to that plan or alternative model'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 or alternative model.

~~(e)~~

(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. 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.

~~SEC. 4.~~

SEC. 5. Section ~~14183.5~~ *14182.15* is added to the Welfare and Institutions Code, to read:

~~14183.5.~~

14182.15. In conjunction with the implementation of Section ~~14183~~ *14182*, the department shall work with counties to develop a method to be used in determining the appropriate contribution to cover the nonfederal share of inpatient hospital expenses for seniors and persons with disabilities in the Medi-Cal program.

~~SEC. 5.~~

SEC. 6. Section ~~14184~~ *14182.2* is added to the Welfare and Institutions Code, to read:

~~14184.~~

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 include at least one of 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) Establish and support medical homes, incorporating all of the following principles:

(A) Each child has a personal physician.

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

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

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

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

(F) Quality and safety practices and measures.

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

(H) Payment is structured appropriately to ~~recognized~~ *recognize* the added value provided to children and their families.

(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.

~~SEC. 6.~~

SEC. 7. Section 15908 of the Welfare and Institutions Code is amended to read:

15908. (a) This part shall become inoperative on the date that the director executes a declaration, which shall be retained by the director and provided to the fiscal and appropriate policy committees of the Legislature, stating that the federal demonstration project provided for in this part has been terminated by the federal Centers for Medicare and Medicaid Services, and shall, six months after the date the declaration is executed, be repealed.

(b) Notwithstanding subdivision (a), the director may alternatively execute a declaration continuing the projects established in this part, to the extent the projects are authorized and consistent with the terms and conditions of a successor federal waiver or demonstration project secured pursuant to Section 14180.

(c) Notwithstanding subdivision (a), the director may continue and administer any extensions, modifications, or continuation of the projects under this part approved by the federal Centers for Medicare and Medicaid Services.

~~SEC. 7.~~

SEC. 8. Part 3.6 (commencing with Section 15909) is added to Division 9 of the Welfare and Institutions Code, to read:

PART 3.6. COVERAGE EXPANSION AND ENROLLMENT DEMONSTRATION PROJECTS

15909. The Legislature finds and declares all of the following:

(a) Pursuant to Section 14180, the Legislature directed the department to apply for a successor federal waiver or demonstration project, in part, to coincide with the end of the waiver described in relevant part in subdivision (b) of Section 15900 to, among other requirements, optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care.

(b) Passage of federal health care reform, pursuant to 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), presents new options of federal support for coverage of low-income individuals and significant expansion of state coverage programs in 2014. Through the success of the Health Care Coverage Initiatives established pursuant to Part 3.5 (commencing with Section 15900), and with implementation of a successor federal Medicaid waiver or demonstration project, California is well positioned to develop enrollment and coverage expansion models that will lead the way to full implementation of comprehensive health care reforms in 2014.

15910. (a) Subject to federal approval of a successor Section 1115 Medicaid waiver or demonstration project effective on or after September 1, 2010, the department shall, by no later than

January 1, 2011, or alternatively, 180 days after federal approval of the successor federal waiver or demonstration project, whichever occurs later, ~~develop~~ *authorize* local Coverage Expansion and Enrollment Demonstration (CEED) projects to provide scheduled health care benefits for uninsured adults 19 to 64, inclusive, years of age, with incomes up to 200 percent of the federal poverty level and who are not otherwise eligible for Medicare or Medi-Cal, consistent with the terms and conditions of the successor federal waiver or demonstration project.

(b) Counties, consistent with the terms and conditions of the successor federal waiver or demonstration project, may perform outreach and enrollment activities to target populations, including, but not limited to, the homeless, individuals who frequently use hospital inpatient or emergency department services for avoidable reasons, or people with mental health *or substance abuse* treatment needs.

(c) CEED projects shall be designed and implemented with the systems and program elements necessary to facilitate the transition of those eligible individuals to Medi-Cal coverage, or alternatively, to coverage through the state health insurance exchange, by 2014, pursuant to state and federal law, and the terms and conditions of the successor federal waiver or demonstration project.

(d) The department shall ~~develop~~ *authorize* projects that meet the requirements and desired outcomes set forth in this part and the terms and conditions of the successor federal waiver or demonstration project.

(e) The projects shall include the following elements, subject to the terms and conditions of the successor federal waiver or demonstration project:

(1) Development of standardized eligibility and enrollment procedures that interface with Medi-Cal processes according to the milestones developed in consultation with the counties, county health departments, public hospitals, and county human service departments. Coverage initiatives shall migrate to the standardized procedures in accordance with the terms and conditions of the successor federal waiver or demonstration project.

(2) (A) Designation of a medical home and assignment of eligible individuals to a primary care provider. For purposes of this paragraph, “medical home” means a single provider or facility that maintains all of an individual’s medical information and, at a

minimum, coordinates health and medical care services for enrolled individuals.

(B) Provision of an enhanced medical home, to be specifically defined by the terms and conditions of the successor federal waiver or demonstration project, that targets those enrollees who are frequent users of public inpatient hospital services or have been diagnosed with chronic medical or mental health conditions. The enhanced medical home may include case management services.

(C) CEED projects shall offer to contract, or subcontract, with an entity licensed as a primary care clinic pursuant to subdivision (a) of Section 1204 of the Health and Safety Code that qualifies to serve as a medical home, as defined in subparagraph (A) of paragraph (2) of subdivision (e) of Section 15910, or an enhanced medical home, as defined in subparagraph (B) of paragraph (2) of subdivision (e) of Section 15910.

(3) Provision of the scheduled benefit package of services required under the terms and conditions of the successor federal waiver or demonstration project described in subdivision (a).

(4) A provider network and service delivery system that includes participation by public and private providers in order to provide the scheduled services in the project, and to ensure the capacity to transition those eligible individuals to the applicable Medi-Cal coverage, or alternatively, to coverage through the state health insurance exchange, in 2014.

(5) Development of an outreach and enrollment plan that does both of the following:

(A) Reaches potential project enrollees.

(B) Includes the public and private providers necessary to serve those eligible individuals in Medi-Cal coverage, or alternatively, in coverage through the state health insurance exchange, beginning in 2014.

(6) A quality measurement and quality monitoring system.

(7) Data tracking systems to provide the department with required data for quality monitoring, quality improvement, and evaluation.

(8) The ability to demonstrate how the CEED projects will promote the viability of the existing safety net health care system.

(9) Demonstration of how the CEED projects will provide consumer assistance to individuals applying for, participating in, or accessing, services in the projects.

(10) Ability to meet program requirements, standards, and performance measurements developed by the department, in consultation with participating counties, for the CEED projects.

(f) A CEED project provider network and service delivery system may include contracts or subcontracts with primary care clinics licensed under subdivision (a) of Section 1204 of the Health and Safety Code.

(g) Services provided pursuant to this part shall be available to those eligible uninsured individuals enrolled in the applicable CEED project. Notwithstanding any other provision of law, nothing in this part shall be construed to create an entitlement program of any kind.

(h) CEED projects shall be established and implemented only to the extent that federal financial participation is available *and only to the extent that available federal financial participation is not jeopardized*.

15911. (a) A county, city and county, consortium of counties serving a region consisting of more than one county, or health authority shall be eligible to apply for a CEED project federal fund allocation.

(b) The department shall develop methodologies for distributing available federal funds for the projects established by this part and for determining the amount of federal funding available, consistent with the terms and conditions of the successor federal waiver or demonstration project.

(c) The department shall seek to balance the allocations throughout geographic areas of the state, consistent with the terms and conditions of the successor federal waiver or demonstration project.

(d) Each county, city and county, consortium of counties, or health authority that chooses *and is authorized by the department* to administer a CEED project and receive federal funding shall provide the necessary local funds for the nonfederal share of the certified public expenditures, or intergovernmental transfers to the extent allowable under the successor federal waiver or demonstration project, required to claim the federal funds made available from the federal allotment. The certified public expenditures or intergovernmental transfers, to the extent allowable under the successor federal waiver or demonstration project, shall meet the requirements of the terms and conditions of the successor

federal waiver or demonstration project referenced in subdivision (a) of Section 15910. Nothing in this part shall be construed to require a political subdivision of the state to participate in the CEED project, and those local funds expended for the nonfederal share of CEED project services under this part shall be considered voluntary contributions for purposes of 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 the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as amended by the Patient Protection and Affordable Care Act.

(e) ~~Selected~~ *CEED* projects shall expend the funds according to an expenditure schedule determined by the department consistent with the terms and conditions of the successor federal waiver or demonstration project described in subdivision (a) of Section 15910.

(f) Except as otherwise provided in the annual Budget Act, no state General Fund moneys shall be used to fund CEED project services, nor to fund any related administrative costs ~~provided to~~ *incurred by* counties or any other political subdivision of the state.

(g) The department may reallocate the available federal funds among selected projects, if necessary, to maximize receipt of federal funds or meet federal requirements regarding the timing of expenditures. Selected projects receiving reallocated funds must have the ability to make the certified public expenditures necessary to claim the applicable reallocated federal funds.

(h) (1) On and after January 1, 2014, California shall implement comprehensive health care reform for the populations targeted by the CEED in compliance with federal health care reform law, regulation, and policy, including 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 subsequent amendments.

(2) To the extent permitted by paragraph (1), implementation of comprehensive health care reform shall include the implementation of prospective payment system reimbursement for federally qualified health centers and rural health clinics as described in Section 14132.100 for federally qualified health services or rural health clinic services to beneficiaries newly covered under the Medi-Cal program and as set forth in

subdivision (d) of Section 1302 of Part I of Subtitle D of the federal Patient Protection and Affordable Care Act.

15912. (a) The department shall ensure that the CEED projects established under this part are evaluated to determine to what extent the projects have met the requirements of the successor federal waiver or demonstration project referenced in this part and successfully developed the necessary systems and program elements required to transition those eligible persons to Medi-Cal coverage, or alternatively, to coverage through the state health insurance exchange, in 2014.

(b) The department may seek federal or private funds or enter into partnership with an independent, nonprofit group or foundation, an academic institution, or a governmental entity providing grants for health-related activities, to evaluate the programs funded under this part.

15913. 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 part, and the terms and conditions of the successor federal waiver or demonstration project secured pursuant to subdivision (a) of Section 15910, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

15914. ~~This~~ *A request for information, or similar process, used by the department to authorize entities to operate CEED projects and any agreements entered into by, or modified by, the department for purposes of this* part shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

15915. In the event of a conflict between a provision of this part and a term or condition of the successor federal waiver or demonstration project pursuant to subdivision (a) of Section 15910, the terms and conditions of the successor federal waiver or demonstration project shall control.

~~SEC. 7.~~

SEC. 9. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes to state funded health care programs at the earliest possible time, it is necessary that this act take effect immediately.

~~SEC. 8. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

~~In order to make changes to state funded health care programs at the earliest possible time, it is necessary that this act take effect immediately.~~

CORRECTIONS:

Text—Pages 4, 5, and 15.

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