Assembly Bill No. 1642

CHAPTER 465

An act to amend Sections 14132.275, 14186.4, 14197, 14197.05, 14302.1, 14409, 14456.5, 14712, 14713, and 14715 of, to add Sections 14197.04 and 14197.7 to, and to repeal Section 14304 of, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor October 2, 2019. Filed with Secretary of State October 2, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1642, Wood. Medi-Cal: managed care plans.

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal regulations require a state that contracts with specified Medicaid managed care plans to develop and enforce network adequacy standards, to ensure that services covered under the Medicaid state plan are available and accessible to enrollees of specified Medicaid managed care plans in a timely manner, and to contract with a qualified external quality review organization (EQRO) to produce annually an external quality review technical report that summarizes findings on access and quality of care. Existing state law establishes, until January 1, 2022, certain time and distance and appointment time standards for specified services consistent with those federal regulations to ensure that Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, and authorizes a Medi-Cal managed care plan to request approval from the department to use alternative access standards for the time and distance standards if specified conditions are met, including that the Medi-Cal managed care plan has exhausted all reasonable options to obtain providers to meet the applicable standard. Existing state law requires a Medi-Cal managed care plan to provide annually to the department, or upon the department's request, a report that demonstrates the Medi-Cal managed care plan's compliance with time and distance standards, and requires the EQRO to compile various data, by plan and by county, related to time and distance standards, including the number of requests for alternative access standards in the plan service area for time and distance.

This bill would require a Medi-Cal managed care plan to provide to the department additional information in its request for the alternative access standards, including a description of the reasons justifying the alternative

access standards, and to demonstrate to the department how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of Medi-Cal covered transportation. The bill would require the department to evaluate, as part of its review and approval of an alternative access standard, if the resulting time and distance is reasonable to expect a beneficiary to travel to receive care. The bill would require a Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard to assist an enrollee who would travel farther than the established time and distance standards in obtaining an appointment with an appropriate provider within established appointment time and distance standards, to arrange for Medi-Cal covered transportation for the enrollee, as determined by the department, and to inform affected members of the approved alternative access standards.

This bill would require the information compiled by the EQRO to include the extent to which each Medi-Cal managed care plan uses clinically appropriate telecommunications technology to meet established time and distance standards.

(2) Existing law requires the Director of Health Care Services, in accordance with specified procedures, to either terminate a contract with or impose one or more specified sanctions, including civil penalties pursuant to federal law, on a prepaid health plan or Medi-Cal managed care plan if the department makes a finding of noncompliance or for other good cause.

This bill would modify criteria for a finding of noncompliance or for other good cause under those provisions. The bill would expand the types of authorized sanctions and bases for sanctions, would raise the maximum limits of certain sanctions based on the number of violations, and would modify the terms of notice. The bill would require the department to use nonfederal moneys collected by the department under these provisions to be deposited into the General Fund for use, and, upon appropriation by the Legislature, would require these moneys to be used to address workforce issues in the Medi-Cal program and to improve access to care in the Medi-Cal program. The bill would condition the implementation of these requirements on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would make technical and conforming changes related to these requirements.

(3) Existing law requires the department to implement managed mental health care for Medi-Cal beneficiaries through contracts with county mental health plans. Under existing law, the county mental health plans are responsible for providing specialty mental health services to beneficiaries, and Medi-Cal managed care health plans are responsible for delivering nonspecialty mental health services to beneficiaries.

Existing law requires the department to notify the mental health plan of the department's determination that a mental health plan has failed to comply with certain provisions, and authorizes the department to impose sanctions. Existing law authorizes the department, if the department imposes fines or

penalties, to offset the fines from certain accounts, including the Mental Health Subaccount.

This bill would instead extend the provisions described under paragraph (2) to mental health plans, and would apply those provisions to additional contractors. The bill would authorize the department to temporarily withhold payments of federal financial participation and payments from the above-described accounts until the department determines the contractor has come into compliance.

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

SECTION 1. Section 14132.275 of the Welfare and Institutions Code is amended to read:

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

(b) After federal approval is obtained, the department shall establish the demonstration project that enables dual eligible beneficiaries to receive a continuum of services that maximizes access to, and coordination of, benefits between the Medi-Cal and Medicare programs and access to the continuum of long-term services and supports and behavioral health services, including mental health and substance use disorder treatment services. The purpose of the demonstration project is to integrate services authorized under the federal Medicaid program (Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)). The demonstration project may also include additional services as approved through a demonstration project or waiver, or a combination of those.

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

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

(2) "Capitated payment model" means an agreement entered into between CMS, the state, and a managed care health plan, in which the managed care health plan receives a capitation payment for the comprehensive, coordinated provision of Medi-Cal services and benefits under Medicare Part C (42 U.S.C. Sec. 1395w-21 et seq.) and Medicare Part D (42 U.S.C. Sec.

1395w-101 et seq.), and CMS shares the savings with the state from improved provision of Medi-Cal and Medicare services that reduces the cost of those services. Medi-Cal services include long-term services and supports as defined in Section 14186.1, behavioral health services, and any additional services offered by the demonstration site.

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

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

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

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

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

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

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

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

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

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

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

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

(g) No sooner than March 1, 2013, demonstration sites shall be established in up to eight counties, and shall include at least one county that provides Medi-Cal services through a two-plan model pursuant to Article 2.7 (commencing with Section 14087.3) and at least one county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5). The director shall consult

with the Legislature, CMS, and stakeholders when determining the implementation date for this section. In determining the counties in which to establish a demonstration site, the director shall consider both of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) (i) Persons meeting requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591) or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section

14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS may select either of these managed care health plans for their Medicare and Medi-Cal benefits if one is available in that county.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The department shall not terminate contracts in a demonstration site with a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive beneficiaries or who have been diagnosed with AIDS and with any entity with a contract pursuant to Chapter 8.75 (commencing with Section 14591), except as provided in the contract or pursuant to state or federal law.

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

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

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

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

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

(3) Reimbursement policies shall not prevent demonstration sites and providers from entering into payment arrangements that allow for the alignment of financial incentives and provide opportunities for shared risk and shared savings in order to promote appropriate utilization shifts, which

encourage the use of home- and community-based services and quality of care for dual eligible beneficiaries enrolled in the demonstration sites.

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

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

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

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

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

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

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

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

(2) (A) By January 1, 2013, or as soon thereafter as practicable, the department shall develop, in consultation with CMS and stakeholders, quality and fiscal measures for health plans to reflect the short- and long-term results of the implementation of this section. The department shall also develop quality thresholds and milestones for these measures. The department shall

update these measures periodically to reflect changes in this program due to implementation factors and the structure and design of the benefits and services being coordinated by managed care health plans.

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

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

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

SEC. 2. Section 14186.4 of the Welfare and Institutions Code is amended to read:

14186.4. (a) This article shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and only if and to the extent that federal financial participation is available.

(b) To implement this article, the department may contract with public or private entities. Contracts, or amendments to current contracts, entered into under this article may be on a noncompetitive bid basis and shall be exempt from all of the following:

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

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

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

(4) Review or approval of feasibility study reports and the requirements of Sections 4819.35 to 4819.37, inclusive, and Sections 4920 to 4928, inclusive, of the State Administrative Manual.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and State Department of Social Services may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the departments shall notify and consult with stakeholders, including beneficiaries, providers, area agencies on aging, independent living centers, and advocates.

(d) Beginning July 1, 2012, the department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of any report submitted to the federal Centers for Medicare and Medicaid Services (CMS) that is required under an approved federal waiver or waiver amendments or any state plan amendment for any long-term services and supports.

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

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

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

(B) The department shall require managed care health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is noncompliant with one or more of the measures set forth in this section, the health plan shall submit, within 60 days, a corrective action plan to the department for approval. The corrective action plan shall include, at a minimum, steps that the health plan shall take to improve its performance based on the standard or standards with which the health plan is out of compliance. The corrective action plan

shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14197.7. This paragraph does not limit the application of Section 14197.7.

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

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

SEC. 3. Section 14197 of the Welfare and Institutions Code is amended to read:

14197. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) Commencing January 1, 2018, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time and distance standards for the following services:

(1) For primary care, both adult and pediatric, 10 miles or 30 minutes from the beneficiary's place of residence.

(2) For hospitals, 15 miles or 30 minutes from the beneficiary's place of residence.

(3) For dental services provided by a Medi-Cal managed care plan, 10 miles or 30 minutes from the beneficiary's place of residence.

(4) For obstetrics and gynecology primary care, 10 miles or 30 minutes from the beneficiary's place of residence.

(c) Commencing July 1, 2018, for the covered benefits under its contracts, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time and distance standards for the following services:

(1) For specialists, as defined in subdivision (h), adult and pediatric, including obstetric and gynecology specialty care, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(2) For pharmacy services, 10 miles or 30 minutes from the beneficiary's place of residence.

(3) For outpatient mental health services, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(4) (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

(B) For opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno,

Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(iv) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(d) (1) (A) A Medi-Cal managed care plan shall comply with the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations, subject to any authorized exceptions in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(B) Commencing July 1, 2018, subparagraph (A) applies to Medi-Cal managed care plans that are not, as of January 1, 2018, subject to the appointment time standards described in subparagraph (A).

(2) A Medi-Cal managed care plan shall comply with the following availability standards for skilled nursing facility services and intermediate care facility services, as follows:

(A) Within five business days of the request for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Within seven business days of the request for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Within 14 calendar days of the request for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Within 14 calendar days of the request for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(3) A county Drug Medi-Cal organized delivery system shall provide an appointment within three business days to an opioid treatment program.

(4) A dental managed care plan shall provide an appointment within four weeks of a request for routine pediatric dental services and within 30 calendar days of a request for specialist pediatric dental services.

(e) (1) The department, upon request of a Medi-Cal managed care plan, may authorize alternative access standards for the time and distance standards established under this section if either of the following occur:

(A) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard.

(B) The department determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

(2) If a Medi-Cal managed care plan cannot meet the time and distance standards set forth in this section, the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department. A request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time and distance standards, if known at that time.

(3) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards based on those facts and circumstances. Effective no sooner than contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall include a description on how the Medi-Cal managed care plan intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time and distance standards specified in subdivision (c). The department may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Medi-Cal managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan's proposal, the department shall inform the Medi-Cal managed care plan of the department's reason for rejecting the proposal. The department shall post any approved alternative access standards on its internet website.

(4) The department may authorize a Medi-Cal managed care plan to use clinically appropriate telecommunications technology as a means of determining annual compliance with the time and distance standards established pursuant to this section or may approve alternative access to care, including telehealth consistent with the requirements of Section 2290.5 of the Business and Professions Code, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.

(5) As part of the department's evaluation of a request submitted by a Medi-Cal managed care plan to utilize an alternative access standard pursuant to this subdivision, the department shall evaluate and determine whether the resulting time and distance is reasonable to expect a beneficiary to travel to receive care.

(f) (1) Effective for contract periods commencing on or after July 1, 2018, a Medi-Cal managed care plan shall, on an annual basis and when requested by the department, demonstrate to the department the Medi-Cal managed care plan's compliance with the time and distance and appointment time standards developed pursuant to this section. The report shall measure

compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(2) Effective for contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall demonstrate, on an annual basis, and when requested by the department, to the department how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of either Medi-Cal covered transportation or clinically appropriate telecommunications technology, as specified in paragraph (4) of subdivision (c), if the enrollees of a Medi-Cal managed care plan needed to obtain health care services from a health care provider or a facility located outside of the time and distance standards, as specified in subdivision (c).

The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(3) Effective for contract periods commencing on or after July 1, 2018, the department shall evaluate on an annual basis a Medi-Cal managed care plan's compliance with the time and distance and appointment time standards implemented pursuant to this section. This evaluation may include, but need not be limited to, annual and random surveys, investigation of complaints, grievances, or other indicia of noncompliance. Nothing in this subdivision shall be construed to limit the appeal rights of a Medi-Cal managed care plan under its contracts with the department.

(4) The department shall publish annually on its internet website a report that details the department's findings in evaluating a Medi-Cal managed care plan's compliance under paragraph (2). At a minimum, the department shall specify in this report those Medi-Cal managed care plans, if any, that were subject to a corrective action plan due to noncompliance with the time and distance and appointment time standards implemented pursuant to this section during the applicable year and the basis for the department's finding of noncompliance. The report shall include a Medi-Cal managed care plan's response to the corrective plan, if available.

(g) The department shall consult with Medi-Cal managed care plans, including mental health plans, health care providers, consumers, providers and consumers of long-term services and supports, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

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

(1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.9 (commencing with Section 14088).

(F) Article 2.91 (commencing with Section 14089).

(G) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700).

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist" means any of the following:

(A) Cardiology/interventional cardiology.

(B) Nephrology.

(C) Dermatology.

(D) Neurology.

(E) Endocrinology.

(F) Ophthalmology.

(G) Ear, nose, and throat/otolaryngology.

(H) Orthopedic surgery.

(I) Gastroenterology.

(J) Physical medicine and rehabilitation.

(K) General surgery.

(L) Psychiatry.

(M) Hematology.

(N) Oncology.

(O) Pulmonology.

(P) HIV/AIDS specialists/infectious diseases.

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

(j) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(k) This section shall remain in effect only until January 1, 2022, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2022, deletes or extends that date.

SEC. 4. Section 14197.04 is added to the Welfare and Institutions Code, immediately following Section 14197, to read:

14197.04. (a) (1) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision (e) of Section 14197, upon the request of an enrollee who is required to travel farther than the time and distance standards, as established in subdivision (c) of Section 14197, shall assist that enrollee in obtaining an appointment with an appropriate specialist provider within the time and distance standards established pursuant to subdivision (c) of Section

14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(2) For purposes of complying with the requirement to assist an enrollee, as specified in paragraph (1), a Medi-Cal managed care plan shall do either of the following:

(A) Make its best effort to establish a member-specific case agreement, at the Medi-Cal fee-for-service rate or a rate mutually agreed upon by the specialist provider and the plan, with an appropriate specialist provider within the time and distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(B) Arrange for an appointment with a network specialist provider within the time and distance standards established pursuant to subdivision (c) of Section 14197, and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(3) The requirements of paragraph (1) shall not apply if there is not a specialist provider with an office location within the applicable time and distance standards in relation to the area within which the enrollee resides or the Medi-Cal managed care plan has attempted to establish a member-specific case agreement with the specialist provider for any enrollee pursuant to subparagraph (A) of paragraph (2) in the most recent fiscal year and the provider refused to enter into a member-specific case agreement.

(b) If a specialist provider is unavailable to render necessary health care services pursuant to subdivision (a) to an enrollee within the time and distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197, as specified in subdivision (a), the Medi-Cal managed care plan or the Medi-Cal fee-for-service program, as determined appropriate by the department, shall arrange for Medi-Cal covered transportation for an enrollee to obtain covered Medi-Cal services pursuant to Section 14132.

(c) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision (e) of Section 14197 shall inform its affected members of the approved alternative access standards in a manner and timeframe, as determined by the department.

(d) (1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.91 (commencing with Section 14089).

(F) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(G) Chapter 8.9 (commencing with Section 14700).

(H) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist provider" has the same meaning as "specialist" as defined in paragraph (2) of subdivision (h) of Section 14197.

SEC. 5. Section 14197.05 of the Welfare and Institutions Code is amended to read:

14197.05. (a) As part of the federally required external quality review organization (EQRO) review of Medi-Cal managed care plans in the annual detailed technical report required by Section 438.364 of Title 42 of the Code of Federal Regulations, effective for contract periods commencing on or after July 1, 2018, the EQRO designated by the department shall compile the data described in subdivision (b), by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197.

(b) (1) The information compiled by the EQRO shall include all of the following:

(A) Number of requests for alternative access standards in the plan service area for time and distance, categorized by provider types, including specialists, and by adult and pediatric.

(B) Number of allowable exceptions for the appointment time standard, if known, categorized by provider types, including specialists, and by adult and pediatric.

(C) Distance and driving time between the nearest network provider and ZIP Code of the beneficiary furthest from that provider for requests for alternative access standards.

(D) Approximate number of beneficiaries impacted by alternative access standards or allowable exceptions.

(E) Percentage of providers in the plan service area, by provider and specialty type, that are under a contract with a Medi-Cal managed care plan.

(F) The number of requests for alternative access standards approved or denied by ZIP Code and provider and specialty type, and the reasons for the approval or denial of the request for alternative access standards. If an approval is authorized, the reasons for approval shall identify whether the approval was granted for either of the following reasons:

(i) A provider was not located in the requested ZIP Code.

(ii) The Medi-Cal managed care plan was unable to enter into a contract with a provider or providers in the requested ZIP Code.

(G) The process of ensuring out-of-network access.

(H) Descriptions of contracting efforts and explanation for why a contract was not executed.

(I) Timeframe for approval or denial of a request for alternative access standards by the department.

(J) Consumer complaints, if any.

(2) The information described in paragraph (1) shall be presented in a chart format to enable comparison among counties, provider types, and plans.

(c) The EQRO shall develop a methodology to assess information that will help inform the experience of individuals placed in a skilled nursing facility or intermediate care facility and the distance that they are placed from their place of residence. The EQRO shall report the results from the use of this methodology in the EQRO annual Medi-Cal managed care plan technical report.

(d) The department shall comply with the requirements of subsection (c) of Section 438.364 of Title 42 of the Code of Federal Regulations in making the information described in this section publicly available.

SEC. 6. Section 14197.7 is added to the Welfare and Institutions Code, to read:

14197.7. (a) Notwithstanding any other law, if the director finds that any entity that contracts with the department for the delivery of health care services (contractor), including a Medi-Cal managed care plan or a prepaid health plan, fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause, the director may terminate the contract or impose sanctions as set forth in this section. Good cause includes, but is not limited to, a finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required contractor reporting to the department.

(b) The director may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits, investigations, contract compliance reviews, quality improvement system monitoring, routine monitoring, facility site surveys, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, health plan rating systems, fair hearing decisions, complaints from beneficiaries and other stakeholders, whistleblowers, and contractor self-disclosures.

(c) Except when the director determines that there is an immediate threat to the health of Medi-Cal beneficiaries receiving health care services from the contractor, at the request of the contractor, the department shall hold a public hearing to commence 30 days after notice of intent to terminate the contract has been received by the contractor. The department shall present evidence at the hearing showing good cause for the termination. The department shall assign an administrative law judge who shall provide a written recommendation to the department on the termination of the contract within 30 days after conclusion of the hearing. Reasonable notice of the hearing shall be given to the contractor, Medi-Cal beneficiaries receiving services through the contractor, and other interested parties, including any other persons and organizations as the director may deem necessary. The notice shall state the effective date of, and the reason for, the termination.

(d) In lieu of contract termination, the director shall have the power and authority to require or impose a plan of correction and issue one or more of the following sanctions against a contractor for findings of noncompliance or good cause, including, but not limited to, those specified in subdivision (a):

(1) Temporarily or permanently suspend enrollment and marketing activities.

(2) Require the contractor to suspend or terminate contractor personnel or subcontractors.

(3) Issue one or more of the temporary suspension orders set forth in subdivision (j).

(4) Impose temporary management consistent with the requirements specified in Section 438.706 of Title 42 of the Code of Federal Regulations.

(5) Suspend default enrollment of enrollees who do not select a contractor for the delivery of health care services.

(6) Impose civil monetary sanctions consistent with the dollar amounts and violations specified in Section 438.704 of Title 42 of the Code of Federal Regulations, as follows:

(A) A limit of twenty-five thousand dollars ($25,000) for each determination of the following:

(i) The contractor fails to provide medically necessary services that the contractor is required to provide, under law or under its contract with the department, to an enrollee covered under the contract.

(ii) The contractor misrepresents or falsifies information to an enrollee, potential enrollee, or health care provider.

(iii) The contractor distributes directly, or indirectly through an agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information.

(B) A limit of one hundred thousand dollars ($100,000) for each determination of the following:

(i) The contractor conducts any act of discrimination against an enrollee on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(ii) The contractor misrepresents or falsifies information that it furnishes to the federal Centers for Medicare and Medicaid Services or to the department.

(C) A limit of fifteen thousand dollars ($15,000) for each beneficiary the director determines was not enrolled because of a discriminatory practice under clause (i) of subparagraph (B). This sanction is subject to the overall limit of one hundred thousand dollars ($100,000) under subparagraph (B).

(e) Notwithstanding the monetary sanctions imposed for the violations set forth in paragraph (6) of subdivision (d), the director may impose

monetary sanctions in accordance with this section based on any of the following:

(1) The contractor violates any federal or state statute or regulation.

(2) The contractor violates any provision of its contract with the department.

(3) The contractor violates any provision of the state plan or approved waivers.

(4) The contractor fails to meet quality metrics or benchmarks established by the department. Any changes to the minimum quality metrics or benchmarks made by the department that are effective on or after January 1, 2020, shall be established in advance of the applicable reporting or performance measurement period, unless required by the federal government.

(5) The contractor fails to demonstrate that it has an adequate network to meet anticipated utilization in its service area.

(6) The contractor fails to comply with network adequacy standards, including, but not limited to, time and distance, timely access, and provider-to-beneficiary ratio requirements pursuant to standards and formulae that are set forth in federal or state law, regulation, state plan or contract, and that are posted in advance to the department's internet website.

(7) The contractor fails to comply with the requirements of a corrective action plan.

(8) The contractor fails to submit timely and accurate network provider data.

(9) The director identifies deficiencies in the contractor's delivery of health care services.

(10) The director identifies deficiencies in the contractor's operations, including the timely payment of claims.

(11) The contractor fails to comply with reporting requirements, including, but not limited to, those set forth in Section 53862 of Title 22 of the California Code of Regulations.

(12) The contractor fails to timely and accurately process grievances or appeals.

(f) (1) Monetary sanctions imposed pursuant to subdivision (e) may be separately and independently assessed and may also be assessed for each day the contractor fails to correct an identified deficiency. For a deficiency that impacts beneficiaries, each beneficiary impacted constitutes a separate violation. Monetary sanctions shall be assessed in the following amounts:

(A) Up to twenty-five thousand dollars ($25,000) for a first violation.

(B) Up to fifty thousand dollars ($50,000) for a second violation.

(C) Up to one hundred thousand dollars ($100,000) for each subsequent violation.

(2) For monetary sanctions imposed on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), the department shall calculate a percentage of the funds attributable to the contractor to be offset per month pursuant to paragraphs (2) to (4), inclusive, of subdivision (n) until the amount offset equals the amount of the penalty imposed pursuant to paragraph (1).

(g) When assessing sanctions pursuant to this section, the director shall determine the appropriate amount of the penalty for each violation based upon one or more of the following nonexclusive factors:

(1) The nature, scope, and gravity of the violation, including the potential harm or impact on beneficiaries.

(2) The good or bad faith of the contractor.

(3) The contractor's history of violations.

(4) The willfulness of the violation.

(5) The nature and extent to which the contractor cooperated with the department's investigation.

(6) The nature and extent to which the contractor aggravated or mitigated any injury or damage caused by the violation.

(7) The nature and extent to which the contractor has taken corrective action to ensure the violation will not recur.

(8) The financial status of the contractor, including whether the sanction will affect the ability of the contractor to come into compliance.

(9) The financial cost of the health care service that was denied, delayed, or modified.

(10) Whether the violation is an isolated incident.

(11) The amount of the penalty necessary to deter similar violations in the future.

(12) Any other mitigating factors presented by the contractor.

(h) Except in exigent circumstances in which there is an immediate risk to the health of beneficiaries, as determined by the department, the director shall give reasonable written notice to the contractor of the intention to impose any of the sanctions authorized by this section and others who may be directly interested, including any other persons and organizations as the director may deem necessary. The notice shall include the effective date for, the duration of, and the reason for each sanction proposed by the director. A contractor may request the department to meet and confer with the contractor to discuss information and evidence that may impact the director's final decision to impose sanctions authorized by this section. The director shall grant a request to meet and confer prior to issuance of a final sanction if the contractor submits the request in writing to the department no later than two business days after the contractor's receipt of director's notice of intention to impose sanctions.

(i) Notwithstanding subdivision (d), the director shall terminate a contract with a contractor that the United States Secretary of Health and Human Services has determined does not meet the requirements for participation in the Medicaid program contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(j) (1) The department may make one or more of the following temporary suspension orders as an immediate sanction:

(A) Temporarily suspend enrollment activities.

(B) Temporarily suspend marketing activities.

(C) Require the contractor to temporarily suspend specified personnel of the contractor.

(D) Require the contractor to temporarily suspend participation by a specified subcontractor.

(2) The temporary suspension orders shall be effective no earlier than 20 days after the notice specified in subdivision (k).

(k) Prior to issuing a temporary suspension order, or temporarily withholding funds pursuant to subdivision (o), the department shall provide the contractor with a written notice. The notice shall state the department's intent to impose a temporary suspension or temporary withhold, and specify the nature and effective date of the temporary suspension or temporary withhold. The contractor shall have 30 calendar days from the date of receipt of the notice to file a written appeal with the department. Upon receipt of a written appeal filed by the contractor, the department shall within 15 days set the matter for hearing, which shall be held as soon as possible, but not later than 30 days after receipt of the notice of hearing by the contractor. The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense. The temporary suspension order shall remain in effect until the hearing is completed and the department has made a final determination on the merits. However, the temporary suspension order shall be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed. The department shall stay imposition of a temporary withhold, pursuant to subdivision (o), until the hearing is completed and the department has made a final determination on the merits.

(*l*) (1) Except as provided in paragraph (2), a contractor may request a hearing in connection with any sanctions applied pursuant to subdivision (d) or (e) within 15 working days after the notice of the effective date of the sanctions has been given, by sending a letter so stating to the address specified in the notice. The department shall stay collection of monetary sanctions upon receipt of the request for a hearing. Collection of the sanction shall remain stayed until the effective date of the final decision of the department.

(2) With respect to mental health plans, the due process and appeals process specified in paragraph (4) of subdivision (b) of Section 14718 shall be made available in connection with any contract termination actions, temporary suspension orders, temporary withholds of funds pursuant to subdivision (o), and sanctions applied pursuant to subdivision (d) or (e).

(m) Except as otherwise provided in this section, all hearings to review the imposition of sanctions, including temporary suspension orders, the withholding or offsetting of funds pursuant to subdivision (n), or the temporary withholding of funds pursuant to subdivision (o), shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(n) (1) If the director imposes monetary sanctions pursuant to this section on a contractor, except for a contractor described in paragraphs (2) to (4), inclusive, the amount of the sanction may be collected by withholding the amount from capitation or other associated payments owed to the contractor.

(2) If the director imposes monetary sanctions on a contractor that is funded from the Mental Health Subaccount, the Mental Health Equity Subaccount, the Vehicle License Collection Account of the Local Revenue Fund, or the Mental Health Account, the director may offset the monetary sanctions from the respective account. The offset shall be subject to paragraph (2) of subdivision (q).

(3) If the director imposes monetary sanctions on a contractor that is funded from the Behavioral Health Subaccount of the Local Revenue Fund 2011, the director may offset the monetary sanctions from that account from the distribution attributable to the applicable contractor. The offset shall be subject to paragraph (2) of subdivision (q).

(4) If the director imposes monetary sanctions on a contractor that is funded from any other mental health or substance use disorder realignment funds from which the Controller is authorized to make distributions to the contractor, the director may offset the monetary sanctions from these funds if the funds described in paragraphs (2) and (3) are insufficient for the purposes described in this subdivision, as appropriate. The offset shall be subject to paragraph (2) of subdivision (q).

(o) (1) Whenever the department determines that a mental health plan or any entity that contracts with the department to provide Drug Medi-Cal services has violated state or federal law, a requirement of this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), or any regulations, the state plan, or a term or condition of an approved waiver, or a provision of its contract with the department, the department may temporarily withhold payments of federal financial participation and payments from the accounts listed in paragraphs (2) to (4), inclusive, of subdivision (n). The department shall temporarily withhold amounts it deems necessary to ensure the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services promptly corrects the violation. The department shall release the temporarily withheld funds when it determines the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services has come into compliance.

(2) A mental health plan, or any entity that contracts with the department to provide Drug Medi-Cal services, may appeal the imposition of a temporary withhold pursuant to this subdivision in accordance with the procedures described in subdivisions (k) and (m). Imposition of a temporary withhold shall be stayed until the effective date of the final decision of the department.

(p) This section shall be read in conjunction with, and apply in addition to, any other applicable law that authorizes the department to impose sanctions or otherwise take remedial action upon contractors.

(q) (1) Notwithstanding any other law, nonfederal moneys collected by the department pursuant to this section, except for moneys collected from a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), shall be deposited into the General Fund for use, and upon appropriation by the Legislature, to

address workforce issues in the Medi-Cal program and to improve access to care in the Medi-Cal program.

(2) Monetary sanctions imposed via offset on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraphs (2) to (4), inclusive, of subdivision (n). The department shall notify the Department of Finance of the percentage reduction for the affected county. The Department of Finance shall subsequently notify the Controller, and the Controller shall redistribute the monetary sanction amount to nonsanctioned counties based on each county's prorated share of the monthly base allocations from the realigned account. With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the applicable account or accounts that are attributable to the contractor in a given month. If the department is not able to collect the full amount of monetary sanctions imposed on a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected.

(r) (1) Notwithstanding Chapter 3.5 (commencing 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, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(2) By July 1, 2025, the department shall adopt any regulations necessary to implement this section in accordance with the requirements of Chapter 3.5 (commencing Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(s) This section shall be implemented only to the extent that any necessary federal approvals have been obtained and that federal financial participation is available.

(t) For purposes of this section, "contractor" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.9 (commencing with Section 14088).

(6) Article 2.91 (commencing with Section 14089).

(7) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(8) Chapter 8.9 (commencing with Section 14700).

(9) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

SEC. 7. Section 14302.1 of the Welfare and Institutions Code is amended to read:

14302.1. (a) (1) Once it is determined that a contract shall be renewed pursuant to this chapter with a prepaid health plan, by the state agency responsible for negotiating these contracts, the agency shall, no later than 25 working days prior to the expiration date of the existing contract or immediately, if that date has passed, draft an extension of the existing contract for a period not to exceed two calendar months. A contract extension shall contain the same terms as the prior existing contract except for the contract's expiration date. The contract extension shall be for a period of time not to exceed two months from the termination date of the original contract.

(2) The state agency responsible for negotiating the contract shall simultaneously submit to each federal and state agency required to approve a contract extension, a draft of the contract for extension no later than 20 working days prior to the expiration date of the prior existing contract.

(3) Each state agency to which an extension for contract has been submitted shall approve or disapprove the extension no later than 10 working days after receipt of the contract.

(4) In the course of any contract negotiations, the responsible state agency shall encourage the participation of other involved state and federal agencies in the negotiation process and shall cooperate with those agencies and with the contractor, or proposed contractor, to seek the resolution of any obstacles to contractual agreement.

(5) No extension shall become effective until and unless federal approval is received indicating that federal funds will be available for services provided under the Medi-Cal program during the period of the contract extension.

(6) These contract extensions shall remain in force and effect until such time as:

(A) The contract expires because the extension date has been reached.

(B) The contract for renewal is entered into and is in force and effect.

(C) The state agency responsible for negotiating the contract determines not to contract or renew a contract with the provider and notifies the provider in writing to that effect.

(D) The state agency responsible for negotiating the contract terminates the contract in accordance with Section 14197.7.

(b) When contract renewals are entered into, the effective date of the contract shall be the termination date of the prior contract, not the ending date of any contract extension. The state agency responsible for negotiating the contract, once a new contract is finalized, shall retroactively make

adjustments in any amounts paid under the contract extension to reflect the new terms and rates of reimbursements as provided in the new contract.

(c) It is the intent of the Legislature to provide for the payment of services provided for under this chapter in a timely and efficient manner. Nothing in this chapter shall be construed as to hinder, prohibit, or interfere with the negotiating and contract process of the responsible state agency and provider.

(d) This section shall apply only to those instances in which both parties have reason to believe that their contract renewal process will not be completed by the termination date of the contract.

SEC. 8. Section 14304 of the Welfare and Institutions Code is repealed.

SEC. 9. Section 14409 of the Welfare and Institutions Code is amended to read:

14409. (a) No prepaid health plan, marketing representative, or marketing organization shall in any manner misrepresent itself, the plans it represents, or the Medi-Cal program. A violation of this section shall include, but is not limited to, all of the following:

(1) False or misleading claims that marketing representatives are employees or representatives of the state, county, or anyone other than the prepaid health plan or the organization by whom they are reimbursed.

(2) False or misleading claims that the prepaid health plan is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the prepaid health plan.

(3) False or misleading claims that the state or county recommends that a Medi-Cal beneficiary enroll in a prepaid health plan.

(4) Claims that a Medi-Cal beneficiary will lose their benefits under the Medi-Cal program or any other health or welfare benefits to which they are legally entitled, if they do not enroll in a prepaid health plan.

(b) Violations of this article or regulations adopted by the department pursuant to this article shall result in one or more of the following sanctions that are appropriate to the specific violation, considering the nature of the offense and frequency of occurrence within the prepaid health plan:

(1) Revocation of one or more permitted methods of marketing.

(2) Termination of authorization for a plan to provide application assistance.

(3) Refusal of the department to accept new enrollments for a period specified by the department.

(4) Refusal of the department to accept enrollments submitted by a marketing representative or organization.

(5) Forfeiture by the plan of all or part of the capitation payments for persons enrolled as a result of such violations.

(6) Requirement that the prepaid health plan in violation of this article personally contact each enrollee enrolled to explain the nature of the violation and inform the enrollee of their right to disenroll.

(7) Application of sanctions as provided in Section 14197.7.

(8) Temporarily suspend capitation payments for beneficiaries enrolled in violation of this article, or regulations adopted thereunder, until the prepaid

health plan is in substantial compliance with the statutory and regulatory requirements.

(c) Any marketing representative who violates subdivision (a) while engaged in door-to-door solicitation is guilty of a misdemeanor, and shall be subject to a fine of five hundred dollars ($500) or imprisonment in a county jail for six months, or both.

SEC. 10. Section 14456.5 of the Welfare and Institutions Code is amended to read:

14456.5. (a) For purposes of this section, Medi-Cal managed care plan means any prepaid health plan or Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries under Chapter 7 (commencing with Section 14000) or this chapter, or Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code.

(b) The department shall ensure that coverage is provided for medically necessary prescription medications and related medically necessary medical services that are prescribed by a local mental health plan provider, and are within the Medi-Cal scope of benefits, but are excluded from coverage under Chapter 8.9 (commencing with Section 14700), by doing, at least, all of the following:

(1) Requiring Medi-Cal managed care plans to comply with the following standards:

(A) The decision regarding responsibility and coverage for a prescription drug shall be made by the Medi-Cal managed care plan within 24 hours, or one business day, from the date the request for a decision is received by telephone or other telecommunication device.

(B) The decision regarding responsibility and coverage for services, such as laboratory tests, that are medically necessary because of medications prescribed by a mental health provider, shall be made by the Medi-Cal managed care plan within seven days following the date the request for a decision is received by telephone or other telecommunication device.

(C) If the decision of the Medi-Cal managed care plan on the request is a deferral because of a determination that the Medi-Cal managed care plan needs more information, the Medi-Cal managed care plan shall transmit notice of the deferral, by facsimile or by other telecommunication system, to the pharmacist or other service provider, to the prescribing mental health provider, and to a designated mental health plan representative. The notice shall set out with specificity what additional information is needed to make a medical necessity determination.

(D) Any denial of authorization or payment for a prescription medication or for any services such as laboratory tests that may be medically necessary because of medications ordered by a mental health plan provider shall set forth the reasons for the denial with specificity. The denial notice shall be transmitted by facsimile or other telecommunication system to the pharmacist or other service provider, to the prescribing mental health provider, to a designated mental health plan representative, and by mail to the Medi-Cal beneficiary.

(E) For purposes of subsequent requests for a medication, the local mental health plan provider prescribing the prescription medication shall be treated as a plan provider under subdivision (a) of Section 1367.22 of the Health and Safety Code.

(F) If the decision cannot be made within five working days because of a request for additional information, any Medi-Cal managed care plan licensed pursuant to Division 2 (commencing with Section 1340) of the Health and Safety Code shall inform the enrollee as required by paragraph (5) of subdivision (h) of Section 1367.01 of the Health and Safety Code. In regard to any Medi-Cal managed care plan contract as described pursuant to subdivision (a) that is issued, amended, or renewed on or after January 1, 2001, with a plan not licensed pursuant to Division 2 (commencing with Section 1340) of the Health and Safety Code, if the decision cannot be made within five working days because of a request for additional information as specified in subparagraph (C), the plan shall notify the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization. All managed care plans shall, upon receipt of all information reasonably necessary for making the decision and that was requested by the plan, approve, modify, or deny the request for authorization within the timeframes specified in subparagraph (A) or (B), whichever applies.

(2) In consultation with the Medi-Cal managed care plans and local mental health plans, establishing a process to recognize credentialing of local mental health plan providers, for the purpose of expediting approval of medications prescribed by a local mental health plan provider who is not contracting with the Medi-Cal managed care plan. In implementing this requirement, the Medi-Cal managed care plan shall not be required to violate licensure, accreditation, or certification requirements of other entities.

(3) Requiring any Medi-Cal managed care plan to enter into a memorandum of understanding with the local mental health plan. The memorandum of understanding shall comply with applicable regulations.

(c) The department may sanction a Medi-Cal managed care plan for violations of this section pursuant to Section 14088.23 or 14197.7.

(d) Every Medi-Cal managed care plan that provides prescription drug benefits and that maintains one or more drug formularies shall provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary of the Medi-Cal managed care plan, by therapeutic category, with an indication of whether any drugs on the list are preferred over other listed drugs. If the Medi-Cal managed care plan maintains more than one formulary, the plan shall notify the requester that a choice of formulary lists is available.

(e) This section shall apply to any contracts entered into, amended, modified, or extended on or after January 1, 2001.

SEC. 11. Section 14712 of the Welfare and Institutions Code is amended to read:

14712. (a) Notwithstanding any other state law, the department shall implement managed mental health care for Medi-Cal beneficiaries through

contracts with mental health plans. Mental health plans may include individual counties, counties acting jointly, or an organization or nongovernmental entity determined by the department to meet mental health plan standards. A contract may be exclusive and may be awarded on a geographic basis.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of specialty mental health services subject to the approval by the department. The agreement may encompass all or any portion of the specialty mental health services provided pursuant to this chapter. This agreement shall not relieve the individual counties of fiscal responsibility for providing these services. Any agreement between counties shall delineate each county's responsibilities and fiscal liability for overpayments.

(c) (1) The department shall contract with a county or counties acting jointly for the delivery of specialty mental health services to each county's eligible Medi-Cal beneficiary population. If a county decides not to contract with the department, does not renew its contract, or is unable to meet the standards set by the department, the county shall inform the department of this decision in writing.

(2) If the county is unwilling to contract for the delivery of specialty mental health services, the department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries.

(3) If the department or county determines that the county is unable to adequately provide specialty mental health services, or that the county does not meet the standards of a mental health plan, the department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries.

(4) The department may contract with qualifying individual counties, counties acting jointly, or other qualified entities approved by the department for the delivery of specialty mental health services in any county that is unable or unwilling to contract with the department. The county may not subsequently contract to provide specialty mental health services under this chapter unless the department elects to contract with the county.

(d) If a county does not contract with the department or other department-approved entity to provide specialty mental health services, the department shall work with the Department of Finance and the Controller to sequester funds from the county that is unable or unwilling to contract in accordance with Section 30027.10 of the Government Code.

SEC. 12. Section 14713 of the Welfare and Institutions Code is amended to read:

14713. (a) The department and mental health plans shall comply with all applicable federal laws, regulations, and the guidelines, standards, and requirements specified in the state plan, waiver, and mental health plan contract, and, except as provided in this chapter, all applicable state statutes and regulations.

(b) If the department determines that a mental health plan has failed to comply with the requirements of Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), Chapter 8.8

(commencing with Section 14600), or this chapter, the department may impose sanctions and plans of correction pursuant to Section 14197.7.

(c) If federal requirements that affect this chapter are changed, it is the intent of the Legislature that state requirements be revised to comply with those changes.

SEC. 13. Section 14715 of the Welfare and Institutions Code is amended to read:

14715. (a) (1) The department shall require any mental health plan that provides Medi-Cal specialty mental health services to enter into a memorandum of understanding with any Medi-Cal managed care plan that provides Medi-Cal health services to some of the same Medi-Cal recipients served by the mental health plan. The memorandum of understanding shall comply with applicable regulations.

(2) For purposes of this section, a "Medi-Cal managed care plan" means any prepaid health plan or Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200), or Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code.

(b) The department shall require the memorandum of understanding to include both of the following:

(1) A process or entity to be designated by the local mental health plan to receive notice of actions, denials, or deferrals from the Medi-Cal managed care plan, and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination.

(2) A requirement that the local mental health plan respond by the close of the business day following the day the deferral notice is received.

(c) This section shall apply to any contracts entered into, amended, modified, extended, or renewed on or after January 1, 2001.

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