An act to amend Section 14132.99 of, and to add Section 14132.991 to, the Welfare and Institutions Code, relating to Medi-Cal.

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

SECTION 1. Section 14132.99 of the Welfare and Institutions Code is amended to read:

14132.99. (a) For the purposes of this section, "facility residents" means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a share of cost. The term "facility residents" also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

~~(b) An additional 500 slots beyond those currently authorized for the home- and community-based Level A/B nursing facility waiver shall be added and 250 of these slots shall be reserved for residents residing in facilities and transitioning out of facilities.~~

~~(c)~~

(b) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

~~(d) The nursing facility Level A/B waivers shall be amended to add the following services:~~

(c) The Nursing Facility/Acute Hospital Transition and Diversion Waiver shall include the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security

deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars ($5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

~~(e) When requesting the renewal of the waiver, the department shall consider expanding the number of waiver slots. Prior to submission of the waiver renewal request, the department shall notify the appropriate fiscal and policy committees of the Legislature of the number of waiver slots included in the waiver renewal request along with supportive data for those slots.~~

~~(f)~~

(d) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services. ~~Contingent upon federal~~

~~approval of the waiver expansion, implementation shall commence within six months of the department receiving authorization for the necessary resources to provide the services to additional waiver participants.~~

SEC. 2. Section 14132.991 is added to the Welfare and Institutions Code, immediately following Section 14132.99, to read:

14132.991. (a) When renewing the Nursing Facility/Acute Hospital Transition and Diversion Waiver, as authorized by subdivision (t) of Section 14132, the director may take the following actions, among others:

(1) Contract with one or more organizations, referred to as a care management contractor, qualified to provide or arrange for delivery of care management and waiver services, including, but not limited to, personal needs assessments, and arranging for services available through public and private agencies, including services available under the waiver, for the waiver participants and applicants. The contract with the care management contractor, the care management contract, may require the care management contractor or their subcontractor, or both, to do all of the following, among other things:

(A) Provide, arrange for, or subcontract with community-based providers for the provision of, waiver services to waiver participants.

(B) Recognize program and service linkages, coordinate service delivery mechanisms and promote prevention of avoidable institutional placement, emergency room visits or inpatient hospital stays, or both, and coordination between health, social, and long-term services and supports by person-centered care planning.

(C) Provide or arrange for, care management to each waiver participant to stabilize their health care, and provide access to home- and community-based services, including managing and anticipating episodes of medical crisis in which transitional care management is needed.

(D) Carry out the waiver's person-centered model of care, pursuant to the requirements set forth in Sections 441.720, 441.725, and 441.540 of Title 42 of the Code of Federal Regulations.

(E) Submit all information and reports required by the department, including, but not limited to, annual financial statements in the timeframe specified by the department.

(F) Pay any providers of waiver services who are not directly employed by or contracted with the care management contractor no less than the rates specified in the waiver or the department's fee schedule, whichever is less, for the provider type.

(G) Bill the department, at the rate established by the state, for all services the care management contractor provides to waiver participants, directly or through a subcontractor or other direct service provider.

(H) Comply with the requirements of the waiver, including any other requirements established by the department regarding waiver operations, including, but not limited to, requirements regarding care coordination. These requirements may be set forth in the care management contract, care management manual, all-county letters, plan letters, plan or provider bulletins or policy letters, or similar instructions.

(2) Propose that the waiver provide for achievement of annual cost neutrality in the aggregate to allow enrollment and authorization of waiver services based on the medical necessity of the waiver services on a case-by-case basis.

(3) Expand the number of waiver slots up to 5,000 additional slots, the director may seek federal approval to amend the waiver to add additional slots or make changes to the waiver model with approval from the Department of Finance.

(4) Require care management contractors to enroll at least 60 percent of all total annual enrollments from either of the following:

(A) Hospital, nursing facility, or other institutional settings assisting members with transitions back to the home or community, or both, setting.

(B) Individuals who had been continuously receiving in home care services, of the type offered under the waiver, under the Early and Periodic Screening, Diagnosis, and Treatment State Plan benefit, California Children Services or Pediatric Palliative Care programs for children, for at least the prior three months but have at the time of transition exceeded the age limit for that benefit.

(5) If the director determines that the care management contractor is not fiscally solvent, or is in danger of becoming fiscally insolvent, the director has the option to immediately terminate the contract with the care management contractor.

(6) Terminate or refuse to renew, in whole or in part, a care management contract when the director determines that the action is necessary to protect the health of the beneficiaries or funds appropriated to the Medi-Cal program.

(b) 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, in whole or in part, by means of all-county letters, plan letters, plan or provider bulletins, policy letters, or other similar instructions, without taking regulatory action.

(c) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and shall be exempt from the review or approval of any division of the Department of General Services.

(d) The department shall implement this section only to the extent it can demonstrate federal cost neutrality as required under the terms of the waiver, and only to the extent any necessary federal approvals are obtained and federal financial participation is available.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Nursing Facility/Acute Hospital Transition and Diversion Waiver.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law provides for various home- and community-based services waivers that promote coverage and services that enable an individual who would otherwise be institutionalized to live at home or in the community. Under the Nursing Facility/Acute Hospital Transition and Diversion Waiver (NF/AH waiver), a home- and community-based services waiver authorized under this federal law until March 31, 2017, home- and community-based services, such as case management and coordination, habilitation services, and community transition services, are provided to eligible Medi-Cal beneficiaries with long-term medical conditions who would otherwise receive care in a skilled nursing facility.

This bill would authorize the Director of Health Care Services, when renewing the NF/AH waiver, to seek additional increases in the scope of the home- and community-based NF/AH waiver. The bill would authorize the Director of Health Care Services to, among other things, expand the number of waiver slots up to 5,000 additional slots and would authorize the Director of Health Care Services to seek federal approval, with approval from the Department of Finance, to add additional slots, beyond these additional 5,000 slots, or to make changes to the waiver model. The bill would authorize the department to implement, interpret, or make specific these provisions by all-county letters, plan letters, plan or provider bulletins, policy letters, or other similar instructions without taking regulatory action. The bill would exempt contracts entered into or amended under this authority from specified provisions of the State Contract Act, specified provisions governing personal services contracts, and the provisions governing the requirement of advertising in the California State Contracts Register. The bill would require the State Department of Health Care Services to implement these provisions only to the extent that it can demonstrate federal cost neutrality, and only to the extent that any necessary federal approvals are obtained and federal financial participation is available. The bill would make conforming changes.

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