

Assembly Bill No. 131

CHAPTER 80

An act to amend Sections 1276, 1797.198, 1797.199, 101317, and 120955 of, and to add Section 123929 to, the Health and Safety Code, to amend Sections 12693.325, 12693.36, 12699.52, 12699.53, 12699.54, 12699.56, 12699.57, 12699.59, and 12699.63 of, and to add Section 12693.50 to, the Insurance Code, and to amend Sections 4643, 4648.4, 4681.5, 4691.6, 4781.5, 4851, 5775, 6606, 14043.46, 14085.6, 14087.54, 14105.48, 14105.7, 14132, 14154, 14495.10, and 16809 of, to amend and repeal Section 14115.8 of, to add Sections 4685.7, 10506, 14001.11, 14011.65, 14093.06, 14105.23, 14105.24, and 14133.23 to, to add and repeal Section 14080 of, and to repeal Section 4685.5 of, the Welfare and Institutions Code, relating to health and human services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor July 19, 2005. Filed with
Secretary of State July 19, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

AB 131, Committee on Budget. Budget Act of 2005: omnibus health trailer bill.

Under existing law, the State Department of Health Services has licensing authority over several categories of clinics and other health facilities. Existing law requires the building standards published in the State Building Standards Code and the regulations adopted by the department to prescribe standards for adequacy, safety, and sanitation of the physical plant, of appropriate staffing, and of services, based on the type of health facility and the needs of the persons served. These regulations are required to permit program flexibility in various contexts, as long as statutory requirements are met, and the use has the prior written approval of the department or of the Office of Statewide Health Planning and Development.

This bill would expand the program flexibility permitted under the department's regulations to include bulk purchasing of pharmaceuticals.

Existing law, the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority within the California Health and Human Services Agency to, among other things, provide statewide coordination of county EMS programs, and to administer the Trauma Care Fund.

Existing law establishes the Trauma Care Fund within the State Treasury and continuously appropriates the fund to the authority for distribution to local EMS agencies. Existing law requires local EMS agencies that receive funding to distribute those funds to eligible trauma

centers and authorizes the local EMS agencies to utilize a grant-based system, a reimbursement-based system, or other appropriate methodology to do so. Existing law requires local EMS agencies to determine the distribution amounts for each trauma center and requires minimum distributions for certain trauma centers to assist those centers in ensuring their viability.

This bill would repeal all minimum distribution requirements, require local EMS agencies to utilize a competitive grant-based system for allocating the funds, and require local EMS agencies to determine distribution of funds based on new criteria.

By requiring that local entities comply with these requirements, this bill would impose a state-mandated local program.

Existing law authorizes the Director of Health Services, to the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, to establish and administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immune deficiency syndrome (AIDS). Under the program, known as the AIDS Drug Assistance Program (ADAP), the State Department of Health Services subsidizes the cost of drugs for the treatment of persons infected with HIV. Under existing law, moneys from the AIDS Drug Assistance Program Rebate Fund, a continuously appropriated fund, are used to cover costs related to the purchase of drugs and services provided through ADAP.

This bill would authorize the department to also subsidize cost-sharing requirements for persons otherwise eligible for the ADAP, up to, but not exceeding, the amount of the person's cost-sharing obligation, in accordance with conditions prescribed in the bill. By expanding the purposes for which moneys from the AIDS Drug Assistance Program Rebate Fund may be expended, the bill would make an appropriation.

Existing law provides for the California Children's Services Program (CCS program), which is administered by the State Department of Health Services and counties, under which services are provided to physically handicapped children under 21 years of age.

This bill, with certain exceptions, would require prior authorization for CCS program services. The bill would authorize, effective July 1, 2004, treatment of, and provider reimbursement for treatment of, certain children participating in the Healthy Families Program, with respect to CCS-eligible medical conditions.

Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to children less than 19 years of age who meet certain criteria, including having a limited household income.

Existing law authorizes, until January 1, 2006, a health, dental, or vision plan participating in the Healthy Families Program to provide application assistance directly to an applicant under designated conditions.

This bill would delete the January 1, 2006, termination date for authorizing application assistance under these conditions.

Existing law requires participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Managed Health Care to be licensed and in good standing with their respective licensing agencies. Existing law authorizes local initiatives, county organized health systems, and special health care authorities that contract with the program, but that do not meet certain licensing requirements, to contract with the board for a limited time period if they are making a good faith effort to meet those licensing requirements.

This bill would delete this limited exemption from licensing requirements for local initiatives, county organized health systems, and special health care authorities.

Existing law provides that it is the intent of the Legislature that the Healthy Families Program comply with the federal State Children's Health Insurance Program.

Existing law establishes the County Health Initiative Matching Fund within the State Treasury to accept intergovernmental transfers as the nonfederal matching fund requirement for federal financial participation through the federal State Children's Health Insurance Program. Existing law authorizes an applicant for an intergovernmental transfer under these provisions to submit a proposal for funding to provide comprehensive health insurance coverage to any child or adult who meets citizenship and immigration status requirements established under federal law, and who meets certain income requirements.

This bill would also authorize proposals for funding to provide comprehensive health insurance coverage to children whose coverage is not eligible for funding under the federal law or to a combination of children, some of whose coverage is eligible for that funding and some of whose coverage is not eligible for that funding. The bill would make conforming changes. The bill would make other revisions to the provisions that authorize local contracts to provide health care benefits through the intergovernmental transfer of funds as the nonfederal matching fund requirement.

Existing law requires each health care service plan and specialized health care service plan that contracts to provide health care benefits under the Healthy Families Program to be licensed by the Department of Managed Health Care or be a county organized health system.

This bill, instead, would require each health care service plan, health insurer, or specialized health care service plan that contracts to provide health care benefits under the program to be licensed either by the Department of Managed Health Care or the Department of Insurance.

Existing law requires that all Healthy Families Program administrative expenses incurred by the board and the department be paid from the County Health Initiative Matching Fund.

This bill would authorize these administrative expenses to be paid directly by applicants, would provide that certain expenses be included as administrative for purposes of this provision, and would authorize the

board to accept funding from not-for-profit groups or foundations or governmental entities to administer the program.

Existing law provides that the state shall be held harmless for any federal disallowance resulting from the Healthy Families Program.

This bill would provide that the state shall also be held harmless for any other expenses or liabilities, including, but not limited to, the cost of processing or granting appeals.

This bill would authorize the board to adopt emergency regulations to implement designated provisions of the bill relating to the Healthy Families Program.

Under existing law, the State Department of Developmental Services provides funding for regional centers for the provision of services and supports to persons with developmental disabilities.

Existing law provides that any person believed to have a developmental disability, and any person believed to have a high risk of parenting a developmentally disabled infant shall be eligible for initial intake and assessment services in the regional centers. Existing law requires that if assessment is needed, prior to July 1, 2005, the assessment shall be performed within 120 days following initial intake, and on and after July 1, 2005, the assessment shall be performed within 60 days following intake.

This bill would permit initial intake to be performed within 120 days following intake prior to July 1, 2006, and would require initial intake to be performed within 60 days following intake on and after July 1, 2006.

Existing law prohibits, during the 2004-05 fiscal year, a regional center from paying any provider of 11 services and supports a rate that is greater than the rate that is in effect on or after June 30, 2004, with exceptions.

This bill, instead, would apply this prohibition during the 2005-06 fiscal year.

Existing law prohibits, during the 2004-05 fiscal year, a regional center from approving any service level for a residential service provider that would result in an increase in the rate to be paid that is greater than the rate that is in effect on or after June 30, 2004, with exceptions.

This bill, instead, would prohibit, during the 2005-06 fiscal year, a regional center from approving any service level for a residential service provider that would result in an increase in the rate to be paid that is greater than the rate that is in effect June 30, 2005, with exceptions.

Existing law requires the department to conduct a pilot project to enhance the ability of a consumer and his or her family to control the decisions and resources required to meet all or part of the objectives of his or her individual program plan. The law requires the department to permit the continuation of the project in 5 regional centers, and expand it to others if certain conditions are met, including, but not limited to, consistency with federal waivers and no impact in the aggregate to the General Fund.

This bill would repeal those provisions. The bill would establish, contingent upon approval of a federal waiver, the Self-Directed Services Program, which would be available in every regional center catchment

area to provide participants, within an individual budget, greater control over needed services and supports, consistent with the requirements set forth in the bill.

Existing law prohibits, during the 2004-05 fiscal year, the department from establishing any permanent payment rate for a community-based day program or in-home respite service agency provider that has a temporary payment rate in effect on June 30, 2004, if that permanent payment rate would be greater than the rate in effect on or after June 30, 2004, except as prescribed. Existing law also prohibits, during the 2004-05 fiscal year, the department from approving an anticipated rate adjusted for a community-based program or in-home respite service agency provider that would result in a similar increase, except as prescribed. Existing law prohibits, during the 2004-05 fiscal year, the department and a regional center from approving any program design modification or revendorization for a community-based day program or in-home respite service agency provider that would result in a similar increase, except as prescribed.

This bill, instead, would apply these prohibitions and exceptions to the 2005-06 fiscal year and to rates in effect on June 30, 2005, if the rates would be greater than the rate in effect on or after June 30, 2005.

Existing law prohibits, during the 2004-05 and 2005-06 fiscal years only, a regional center from expending any purchase of service funds for the startup of any new program, with exceptions.

This bill would limit this prohibition, instead, to the 2005-06 fiscal year.

Existing law specifies that designated habilitation services be provided to adults with developmental disabilities. Under existing law, these services include group job coaching services, in a group supported employment placement at a job coach-to-consumer ratio of not less than 1-to-4 nor more than 1-to-8, where services to a minimum of 4 consumers are funded by the regional center or the Department of Rehabilitation.

This bill would lower the above participant ratio for group services to not less than 1-to-3 nor more than 1-to-8, where services to a minimum of 3 consumers are funded by the regional center or the Department of Rehabilitation.

Existing law requires the establishment of a standard set of guidelines that governs the provision of managed Medi-Cal mental health services at the local level, consistent with federal law. Under existing law, regulations adopted pursuant to this requirement to implement the second phase of mental health managed care are to remain in effect until January 1, 2006.

This bill would require these emergency regulations to remain in effect until permanent regulations are adopted, or June 30, 2006, whichever occurs first.

Under existing law, a person who is committed as a sexually violent predator is required to be provided with programming by the State Department of Mental Health, to afford the person with treatment for his or her diagnosed mental disorder.

This bill would require a sexually violent predator who has been committed and who declines treatment to be offered the opportunity to participate in treatment on at least a monthly basis. The bill would authorize the department to provide mental health treatment programming using an outpatient/day treatment model in accordance with requirements set forth in the bill. In implementing these provisions, the bill would authorize the voluntary suspension of health facility beds at Coalinga State Hospital for a period of up to 6 years, and would authorize the hospital to return the suspended beds to active license status upon request to the State Department of Health Services, if they comply with current operational licensure requirements. This bill would require the State Department of Mental Health to conduct monthly treatment planning conferences with each patient who has chosen not to participate in a specific course of offender treatment.

Existing law provides for various health and public social services programs.

This bill would require the State Department of Health Services and State Department of Alcohol and Drug Programs, for prescribed programs, and Managed Risk Medical Insurance Board, State Department of Developmental Services, State Department of Mental Health, Department of Rehabilitation, and Department of Child Support Services to submit to the Department of Finance for its approval all assumptions underlying all estimates used to develop the departments' budgets, by September 10 of each year, and as revised by March 1 of the following year. The bill would provide that the assumptions would be deemed accepted by the Department of Finance if not approved, modified, or denied within 15 days of submission. The bill would also require each of these entities to submit to the Department of Finance an estimate of expenditures for each of the categorical aid programs in its budget by November 1 of each year, and as revised by April 20 of the following year.

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

Existing federal law requires, as a condition of the state plan and receipt of federal financial assistance for purposes of the Medi-Cal program, the state to comply with requirements relating to Medicare prescription drug low-income subsidies and Medicare transitional prescription drug assistance.

This bill would require the department to implement these federal requirements. The bill would provide that eligibility and enrollment functions required under these provisions shall be a county function and responsibility, subject to the direction, authority, and regulations of the department. The bill would require the department to seek federal approval of any amendments to the state plan necessary to implement these provisions and would provide that these provisions shall be implemented only to the extent that federal financial participation is available.

Because this bill would require each county to perform new eligibility and enrollment functions, it would impose a state-mandated local program.

This bill would require the state to administer, to the extent allowed under federal law, and only if federal financial participation is available, the Medi-Cal to Healthy Families Accelerated Enrollment program, to provide certain low-income children with temporary health benefits for the period during which the child has an application pending for coverage under the Healthy Families Program. The bill would require the Managed Risk Medical Insurance Board to consult and coordinate with the State Department of Health Services to implement the program. The bill would require the department seek approval of any necessary amendments to its state plan and to obtain all necessary federal approvals before implementing the Medi-Cal to Healthy Families Accelerated Enrollment program. This bill would require the department to implement the program on the first day of the 3rd month following the month in which federal approval is received, or on August 1, 2006, whichever is later. Because the bill would impose additional requirements on counties administering the Medi-Cal program, it would impose a state-mandated local program.

Existing law, the California Adult Day Health Care Act, provides for the licensure and regulation of adult day health centers, with administrative responsibility for this program shared between the State Department of Health Services and the California Department of Aging. The Adult Day Health Medi-Cal Law establishes adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain criteria. Existing law authorizes the department to implement a one-year moratorium on the certification and enrollment into the Medi-Cal program of adult day health care centers on a statewide basis or within a geographic area. Existing law exempts, or in some cases authorizes the department to except from the moratorium, applicants that meet certain conditions.

This bill would add to the types of facilities to which the moratorium would not apply.

Under existing law, one of the services provided under the Medi-Cal program is dental services, subject to limitations.

This bill would limit, with certain exceptions, reimbursement to providers of dental services provided to individuals 21 years of age and older at the time of the service to not more than \$1,800 per beneficiary in any calendar year, commencing January 1, 2006. The bill would require the department to pursue any state plan amendment or other federal approval necessary and would provide that this provision shall be implemented only to the extent that federal financial participation is available and necessary to implement this provision. The bill would repeal these provisions as of January 1, 2009.

Existing law permits hospitals contracting with the department to provide Medi-Cal services that meet the criteria for disproportionate share hospital status to be eligible to negotiate with the California Medical Assistance Commission for distributions from the Emergency Services and Supplemental Payments Fund.

Existing law requires, however, that, in order to qualify for distributions from that fund, a hospital to meet specified criteria, including being able to demonstrate a purpose for additional funding, including proposals relating to emergency services and other health care services.

This bill would specify that these proposals may include infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (Baby-BIG).

Existing law provides for various options for the provision of Medi-Cal services pursuant to a managed care plan, including managed care pilot projects in designated geographic areas.

This bill would require the department to perform an evaluation to determine the readiness of an affected Medi-Cal managed care plan to commence operations based upon the action of the director that expands the geographic area of Medi-Cal managed care. The bill would specify the minimum contents of the evaluation.

Existing law authorizes a county board of supervisors, by ordinance, to establish a commission to negotiate the exclusive contract with the California Medical Assistance Commission to provide, or arrange for the provision of, health care services provided under the Medi-Cal program.

This bill would additionally authorize the commission operating in Santa Cruz and Monterey Counties pursuant to the above provisions to enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program, if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs.

Existing law prohibits, until September 1, 2008, any California Children's Services (CCS) covered services from being incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, with the exception of contracts entered into for county organized health systems or the Regional Health Authority in the designated counties.

This bill would impose various requirements on any managed care contractor authorized to provide CCS-covered services pursuant to the above provisions that proposes to expand to other counties, including, among others, demonstrating how the contractor will maintain and comply with designated CCS program standards and Medi-Cal eligibility regulations. The bill would provide that a child enrolled with a managed care contractor that is seeking CCS program benefits would retain certain appeal and fair hearing rights. The bill would also require the state, in consultation with stakeholders, to develop unique pediatric plan performance standards and measurements.

Existing law establishes provider reimbursement rates for covered services.

This bill would prohibit reimbursement under the Medi-Cal program for portable X-ray transportation services from exceeding 100% of the lowest

maximum allowance for California established by the federal Medicare Program for the same or similar services.

This bill would authorize clinics and hospital outpatient projects, except for emergency rooms, owned or operated by Los Angeles County that participated in the California Section 1115 Medicaid Demonstration Project for the county and received 100% cost-based reimbursement pursuant to the special terms and conditions of that waiver to continue to be reimbursed under a cost-based methodology on and after July 1, 2005.

Existing law requires the department to establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment, as defined. Under existing law, specific reimbursement requirements apply with respect to wheelchairs and wheelchair accessories.

This bill would also apply the reimbursement requirements applicable to wheelchairs and wheelchair accessories to speech-generating devices and related accessories.

Existing law requires the director to update allowable drug product prices no less often than every 30 days, with these updates to include any prior change in drug product price of which the director has received notice.

This bill would, instead, require the director to update allowable drug product prices within 7 days of receiving notice of a drug product price change.

Existing law requires the department to amend the Medicaid state plan with respect to the billing option for services by local education agencies to ensure that schools are reimbursed for all eligible services that they provide that are not precluded by federal requirements. Existing law establishes other duties of the department with respect to Medi-Cal billing and reimbursement pertaining to local education agencies and public schools. Certain of these provisions become inoperative on January 1, 2006.

This bill would, instead, provide for the repeal of these local education agencies' billing provisions on January 1, 2010.

Existing law sets forth a schedule of benefits that are covered under the Medi-Cal program, and the conditions pursuant to which these benefits are covered. Under existing law, covered benefits include, among others, prosthetic and orthotic devices, eyeglasses, and orthopedic and conventional shoes.

This bill would also include as a Medi-Cal covered benefit therapeutic shoes and inserts for beneficiaries with diabetes, subject to utilization controls, and to the extent that federal financial participation is available.

Existing law provides various health care benefits under the Medi-Cal program, including drug benefits.

This bill would prohibit, commencing January 1, 2006, drug benefits from being provided under the Medi-Cal program to a full-benefit dual eligible beneficiary, except at the election of the department, upon the approval of the Department of Finance, and to the extent that federal

financial participation is available. This bill would also provide for emergency drug benefits for a full-benefit dual eligible beneficiary, including, commencing January 1, 2006, drug benefits for which federal financial participation is not available, if the Legislature has made a specific appropriation for that purpose. The bill defines a full-benefit dual eligible as an individual who is eligible for full scope services under the Medi-Cal program and coverage for drugs under a prescription drug plan or Medicare Advantage prescription drug plan under the federal Medicare Program. This bill would require the department to seek approval of any amendments to the state plan necessary to implement this provision.

Existing law establishes the Medi-Cal-to-Healthy Families Bridge Benefits Program to provide any child who meets certain criteria with 2 months of health care benefits in order to provide the child with an opportunity to apply for the Healthy Families Program.

This bill would require a child who is determined to change from no share of cost under the Medi-Cal program to a share of cost who meets certain eligibility criteria for the Healthy Families Program to be placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program and would require that 90% of those families be notified about the Healthy Families Program. The bill would establish other requirements and standards for notifications and requests for consent to send Medi-Cal annual redetermination forms to the Healthy Families Program on behalf of these families. The bill would impose related procedural requirements on the department.

By imposing notification requirements upon each county, this bill would create a state-mandated local program.

Existing law requires the department to establish a pilot program to provide continuous skilled nursing care as a benefit under the Medi-Cal program when those services are provided pursuant to a federal waiver. This provision is repealed as of January 1, 2006.

This bill would extend this repeal date to January 1, 2008.

Existing law provides that the board of supervisors of a county that contracted with the State Department of Health Services pursuant to a specified provision of law during the 1990-91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medi-Cal Services Program for state administration of health care services to eligible persons in the county.

This bill would revise, for the 2005-06 fiscal year, state and counties financial responsibilities for certain increases in costs in the County Medi-Cal Services Program.

Existing law, the Mental Health Services Act, was approved by the voters in November 2004 as Proposition 63, an initiative measure. Under the act, the State Department of Mental Health is required, among other things, to distribute funds for local assistance for designated mental health programs.

This bill would require the Director of Mental Health, at the time of the release of the January 10 budget plan and the May Revision, to submit information to the Legislature regarding the expenditure of Proposition 63 funding for each state department and each major program category. The bill would also require the director to submit to the fiscal committees of the Legislature each fiscal year written notice of the intention to spend Proposition 63 local assistance funding in excess of the amounts presented in the department's May Revision projection for that fiscal year.

Existing law authorizes the State Department of Health Services, in administering the Medi-Cal program, to contract with any qualified individual, organization, or entity to provide services to Medi-Cal beneficiaries, including the delivery of services on a managed care basis. Under existing law, Medi-Cal services may be provided to a beneficiary or eligible applicant by an individual provider, or through a prepaid managed health care plan, pilot project, or fee-for-service case management provider.

This bill would require the State Department of Health Services to provide the fiscal and policy committees of the Legislature with quarterly updates, commencing January 1, 2006, regarding core activities to improve the Medi-Cal Managed Care Program and to expand to 13 new counties, as directed by the Budget Act of 2005. The bill would set forth the topics to be included in the quarterly updates, including information regarding state plan amendments and federal waivers.

Existing law, which becomes inoperative on September 1, 2007, imposes various requirements on the State Department of Health Services with respect to the implementation of a plan and the allocation of federal funds to local health jurisdictions for bioterrorism preparedness. Existing law separately requires the department to establish and administer a permanent California Office of Binational Border Health to facilitate cooperation between health officials and health professionals in California and Mexico, to reduce the risk of disease in the California border region, and in those areas directly affected by border health conditions.

This bill would require the department to coordinate its federal bioterrorism activities, as applicable, with the California Office of Binational Border Health as the single point of coordination on border health activities. This bill would separately declare legislative intent that the department audit the cost reports submitted by local health jurisdictions every 3 years, commencing in January 2007, to determine compliance with federal requirements and consistency with local health jurisdiction budgets, contingent upon the availability of federal funding for both these auditing activities and bioterrorism preparedness.

This bill would require the State Department of Developmental Services to include explicit language in its contracts with regional center agencies requiring each regional center to use funds allocated in the Budget Act of 2005 to comply with Medicaid Home and Community-Based Services Waiver requirements for the 2005-06 fiscal year and thereafter. The bill would authorize the department to take disciplinary action against a

regional center that expends these funds for a purpose other than compliance with the waiver requirements. The bill would impose related reporting requirements on each regional center.

This bill would require the State Department of Health Services and the California Medical Assistance Commission to provide annual fiscal information to the Joint Legislative Audit Committee and the Joint Legislative Budget Committee on the funds provided to the contract hospitals participating in the Medi-Cal program and the health plans participating in the Medi-Cal managed care program, for implementation of nurse-to-patient ratios.

This bill would also require the department to provide the Legislature, by July 1, 2009, with data comparing the University of California, Davis baseline study released in May 2002 of nurse staffing levels to staffing of registered nurse and other licensed nurse staffing subsequent to the full implementation of the licensed nurse-to-patient ratios on January 1, 2008, in accordance with the UC Davis study.

Existing law establishes the Major Risk Medical Insurance Fund in the State Treasury, that is continuously appropriated to the Major Risk Medical Insurance Board for specified purposes. Existing law requires, after June 30, 1991, that specific dollar amounts are to be deposited annually in the fund from the Hospital Services, Physician Services, and Unallocated accounts in the Cigarette and Tobacco Products Surtax Fund.

This bill, notwithstanding the above provisions, would require the Controller, upon order of the Director of Finance, to make specified one-time reductions in the amounts deposited into the fund from these accounts into the fund for the 2005-06 budget year. The bill would reappropriate certain amounts from these accounts, so appropriated in the Budget Act of 2005, to the California Healthcare for Indigents Program and the rural health services program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

Appropriation: yes.

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

SECTION 1. Section 1276 of the Health and Safety Code is amended to read:

1276. (a) The building standards published in the State Building Standards Code by the Office of Statewide Health Planning and

Development, and the regulations adopted by the state department shall, as applicable, prescribe standards of adequacy, safety, and sanitation of the physical plant, of staffing with duly qualified licensed personnel, and of services, based on the type of health facility and the needs of the persons served thereby.

(b) These regulations shall permit program flexibility by the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the department or the office, as applicable. The approval of the department or the office shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or office regarding the exception, as applicable.

(c) While it is the intent of the Legislature that health facilities shall maintain continuous, ongoing compliance with the licensing rules and regulations, it is the further intent of the Legislature that the state department expeditiously review and approve, if appropriate, applications for program flexibility. The Legislature recognizes that health care technology, practice, pharmaceutical procurement systems, and personnel qualifications and availability are changing rapidly. Therefore, requests for program flexibility require expeditious consideration.

(d) The state department shall, on or before April 1, 1989, develop a standardized form and format for requests by health facilities for program flexibility. Health facilities shall thereafter apply to the state department for program flexibility in the prescribed manner. After the state department receives a complete application requesting program flexibility, it shall have 60 days within which to approve, approve with conditions or modifications, or deny the application. Denials and approvals with conditions or modifications shall be accompanied by an analysis and a detailed justification for any conditions or modifications imposed. Summary denials to meet the 60-day timeframe shall not be permitted.

(e) Notwithstanding any other provision of law or regulation, the State Department of Health Services shall provide flexibility in its pharmaceutical services requirements to permit any state department that operates state facilities subject to these provisions to establish a single statewide formulary or to procure pharmaceuticals through a departmentwide or multidepartment bulk purchasing arrangement. It is the intent of the Legislature that consolidation of these activities be permitted in order to allow the more cost-effective use and procurement of pharmaceuticals for the benefit of patients and residents of state facilities.

SEC. 1.1. Section 1797.198 of the Health and Safety Code is amended to read:

1797.198. The Legislature finds and declares all of the following:

(a) Trauma care is an essential public service. It is as vital to the safety of the public as the services provided by law enforcement and fire departments. In communities with access to trauma centers, mortality and

morbidity rates from traumatic injuries are significantly reduced. For the same reasons that each community in California needs timely access to the services of skilled police, paramedics, and fire personnel, each community needs access to the services provided by certified trauma centers.

(b) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(c) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury, and serious disability necessitating expensive long-term care.

(d) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(e) It is essential for persons in need of trauma care to receive that care within the 60-minute period immediately following injury. It is during this period, referred to as the “golden hour,” when the potential for survival is greatest, and the need for treatment for shock or injury is most critical.

(f) It is the intent of the Legislature in enacting this act to promote access to trauma care by ensuring the availability of services through EMS agency-designated trauma centers.

SEC. 1.2. Section 1797.199 of the Health and Safety Code is amended to read:

1797.199. (a) There is hereby created in the State Treasury, the Trauma Care Fund, which, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated without regard to fiscal years to the authority for the purposes specified in subdivision (c).

(b) The fund shall contain any moneys deposited in the fund pursuant to appropriation by the Legislature or from any other source, as well as, notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund.

(c) Moneys in the fund shall be expended by the authority to provide for allocations to local EMS agencies, for distribution to local EMS agency-designated trauma centers provided for by this chapter.

(d) Within 30 days of the effective date of the enactment of an appropriation for purposes of implementing this chapter, the authority shall request all local EMS agencies with an approved trauma plan, that includes at least one designated trauma center, to submit within 45 days of the request the total number of trauma patients and the number of trauma patients at each facility that were reported to the local trauma registry for the most recent fiscal year for which data are available, pursuant to Section 100257 of Title 22 of the California Code of Regulations. However, the local EMS agency’s report shall not include any registry entry that is in reference to a patient who is discharged from the trauma center’s emergency department without being admitted to the hospital unless the nonadmission is due to the patient’s death or transfer to another facility. Any local EMS agency that fails to provide these data shall not receive funding pursuant to this section.

(e) Except as provided in subdivision (m), the authority shall distribute all funds to local EMS agencies with an approved trauma plan that includes at least one designated trauma center in the local EMS agency's jurisdiction as of July 1 of the fiscal year in which funds are to be distributed.

(1) The amount provided to each local EMS agency shall be in the same proportion as the total number of trauma patients reported to the local trauma registry for each local EMS agency's area of jurisdiction compared to the total number of all trauma patients statewide as reported under subdivision (d).

(2) The authority shall send a contract to each local EMS agency that is to receive funds within 30 days of receiving the required data and shall distribute the funds to a local EMS agency within 30 days of receiving a signed contract and invoice from the agency.

(f) Local EMS agencies that receive funding under this chapter shall distribute all those funds to eligible trauma centers, except that an agency may expend 1 percent for administration. It is the intent of the Legislature that the funds distributed to eligible trauma centers be spent on trauma services. The funds shall not be used to supplant existing funds designated for trauma services or for training ordinarily provided by the trauma hospital. The local EMS agency shall utilize a competitive grant-based system. All grant proposals shall demonstrate that funding is needed because the trauma center cares for a high percentage of uninsured patients. Local EMS agencies shall determine distribution of funds based on whether the grant proposal satisfies one or more of the following criteria:

(1) The preservation or restoration of specialty physician and surgeon oncall coverage that is demonstrated to be essential for trauma services within a specified hospital.

(2) The acquisition of equipment that is demonstrated to be essential for trauma services within a specified hospital.

(3) The creation of overflow or surge capacity to allow a trauma hospital to respond to mass casualties resulting from an act of terrorism or natural disaster.

(4) The coordination or payment of emergency, nonemergency, and critical care ambulance transportation that would allow for the time-urgent movement or transfer of critically injured patients to trauma centers outside of the originating region so that specialty services or a higher level of care may be provided as necessary without undue delay.

(g) A trauma center shall be eligible for funding under this section if it is designated as a trauma center by a local EMS agency pursuant to Section 1798.165 and complies with the requirements of this section. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(h) A trauma center that receives funding under this section shall agree to remain a trauma center through June 30 of the fiscal year in which it receives funding. If the trauma center ceases functioning as a trauma

center, it shall pay back to the local EMS agency a pro rata portion of the funding that has been received. If there are one or more trauma centers remaining in the local EMS agency's service area, the local EMS agency shall distribute the funds among the other trauma centers. If there is no other trauma center within the local EMS agency's service area, the local EMS agency shall return the moneys to the authority.

(i) In order to receive funds pursuant to this section, an eligible trauma center shall submit, pursuant to a contract between the trauma center and the local EMS agency, relevant and pertinent data requested by the local EMS agency. A trauma center shall demonstrate that it is appropriately submitting data to the local EMS agency's trauma registry and a local EMS agency shall audit the data annually within two years of a distribution from the local EMS agency to a trauma center. Any trauma center receiving funding pursuant to this section shall report to the local EMS agency how the funds were used to support trauma services.

(j) It is the intent of the Legislature that all moneys appropriated to the fund be distributed to local EMS agencies during the same year the moneys are appropriated. To the extent that any moneys are not distributed by the authority during the fiscal year in which the moneys are appropriated, the moneys shall remain in the fund and be eligible for distribution pursuant to this section during subsequent fiscal years.

(k) By October 31, 2002, the authority shall develop criteria for the standardized reporting of trauma patients to local trauma registries. The authority shall seek input from local EMS agencies to develop the criteria. All local EMS agencies shall utilize the trauma patient criteria for reporting trauma patients to local trauma registries by July 1, 2003.

(l) By December 31 of the fiscal year following any fiscal year in which funds are distributed pursuant to this section, a local EMS agency that has received funds from the authority pursuant to this chapter shall provide a report to the authority that details the amount of funds distributed to each trauma center, the amount of any balance remaining, and the amount of any claims pending, if any, and describes how the respective centers used the funds to support trauma services. The report shall also describe the local EMS agency's mechanism for distributing the funds to trauma centers, a description of their audit process and criteria, and a summary of the most recent audit results.

(m) The authority may retain from any appropriation to the fund an amount sufficient to implement this section, up to two hundred eighty thousand dollars (\$280,000). This amount may be adjusted to reflect any increases provided for wages or operating expenses as part of the authority's budget process.

SEC. 1.3. Section 101317 of the Health and Safety Code is amended to read:

101317. (a) For purposes of this article, allocations shall be made to the administrative bodies of qualifying local health jurisdictions described as public health administrative organizations in Section 101185, and pursuant to Section 101315, in the following manner:

(1) (A) For the 2003–04 fiscal year and subsequent fiscal years, to the administrative bodies of each local health jurisdiction, a basic allotment of one hundred thousand dollars (\$100,000), subject to the availability of funds appropriated in the annual Budget Act or some other act.

(B) For the 2002–03 fiscal year, the basic allotment of one hundred thousand dollars (\$100,000) shall be reduced by the amount of federal funding allocated as part of a basic allotment for the purposes of this article to local health jurisdictions in the 2001–02 fiscal year.

(2) (A) Except as provided in subdivision (c), after determining the amount allowed for the basic allotment as provided in paragraph (1), the balance of the annual appropriation for purposes of this article, if any, shall be allotted on a per capita basis to the administrative bodies of each local health jurisdiction in the proportion that the population of that local health jurisdiction bears to the population of all eligible local health jurisdictions of the state.

(B) The population estimates used for the calculation of the per capita allotment pursuant to subparagraph (A) shall be based on the Department of Finance’s E-1 Report, “City/County Populations Estimates with Annual Percentage Changes” as of January 1 of the previous year. However, if within a local health jurisdiction there are one or more city health jurisdictions, the local health jurisdiction shall subtract the population of the city or cities from the local health jurisdiction total population for purposes of calculating the per capita total.

(b) If the amounts appropriated are insufficient to fully fund the allocations specified in subdivision (a), the department shall prorate and adjust each local health jurisdiction’s allocation so that the total amount allocated equals the amount appropriated.

(c) For the 2002–03 fiscal year and subsequent fiscal years, where the federally approved collaborative state-local plan identifies an allocation method, other than the basic allotment and per capita method described in subdivision (a), for specific funding to a local public health jurisdiction, including, but not limited to, funding laboratory training, chemical and nuclear terrorism preparedness, smallpox preparedness, and information technology approaches, that funding shall be paid to the administrative bodies of those local health jurisdictions in accordance with the federally approved collaborative state-local plan for bioterrorism preparedness and other public health threats in the state.

(d) Funds appropriated pursuant to the annual Budget Act or some other act for allocation to local health jurisdictions pursuant to this article shall be disbursed quarterly to local health jurisdictions beginning July 1, 2002, using the following process:

(1) Each fiscal year, upon the submission of an application for funding by the administrative body of a local health jurisdiction, the department shall make the first quarterly payment to each eligible local health jurisdiction. Initially, that application shall include a plan and budget for the local program that is in accordance with the department’s plans and priorities for bioterrorism preparedness and response, and other public

health threats and emergencies, and a certification by the chairperson of the board of supervisors or the mayor of a city with a local health department that the funds received pursuant to this article will not be used to supplant other funding sources in violation of subdivision (d) of Section 101315. In subsequent years, the department shall develop a streamlined process for continuation of funding that will address new federal requirements and will assure the continuity of local plan activities.

(2) The department shall establish procedures and a format for the submission of the local health jurisdiction's plan and budget. The local health jurisdiction's plan shall be consistent with the department's plans and priorities for bioterrorism preparedness and response and other public health threats and emergencies in accordance with requirements specified in the department's federal grant award. Payments to local health jurisdictions beyond the first quarter shall be contingent upon the approval of the department of the local health jurisdiction's plan and the local health jurisdiction's progress in implementing the provisions of the local health jurisdiction's plan, as determined by the department.

(3) If a local health jurisdiction does not apply or submits a noncompliant application for its allocation, those funds provided under this article may be redistributed according to subdivision (a) to the remaining local health jurisdictions.

(e) Funds shall be used for activities to improve and enhance local health jurisdictions' preparedness for and response to bioterrorism and other public health threats and emergencies, and for any other purposes, as determined by the department, that are consistent with the purposes for which the funds were appropriated.

(f) Any local health jurisdiction that receives funds pursuant to this article shall deposit them in a special local public health preparedness trust fund established solely for this purpose before transferring or expending the funds for any of the uses allowed pursuant to this article. The interest earned on moneys in the fund shall accrue to the benefit of the fund and shall be expended for the same purposes as other moneys in the fund.

(g) (1) A local health jurisdiction that receives funding pursuant to this article shall submit reports that display cost data and the activities funded by moneys deposited in its local public health preparedness trust fund to the department on a regular basis in a form and according to procedures prescribed by the department.

(2) The department, in consultation with local health jurisdictions, shall develop required content for the reports required under paragraph (1), which shall include, but shall not be limited to, data and information needed to implement this article and to satisfy federal reporting requirements. The chairperson of the board of supervisors or the mayor of a city with a local health department shall certify the accuracy of the reports and that the moneys appropriated for the purposes of this article have not been used to supplant other funding sources.

(3) It is the intent of the Legislature that the department shall audit the cost reports every three years, commencing in January 2007, to determine

compliance with federal requirements and consistency with local health jurisdiction budgets, contingent upon the availability of federal funds for this activity, and contingent upon the continuation of federal funding for bioterrorism preparedness.

(h) The administrative body of a local health jurisdiction may enter into a contract with the department and the department may enter into a contract with that local health jurisdiction for the department to administer all or a portion of the moneys allocated to the local health jurisdiction pursuant to this article. The department may use funds retained on behalf of a local jurisdiction pursuant to this subdivision solely for the purposes of administering the jurisdiction's bioterrorism preparedness activities. The funds appropriated pursuant to this article and retained by the department pursuant to this subdivision are available for expenditure and encumbrance for the purposes of support or local assistance.

(i) The department may recoup from a local health jurisdiction any moneys allocated pursuant to this article that are unspent or that are not expended for purposes specified in subdivision (d). The department may also recoup funds expended by a local health jurisdiction in violation of subdivision (d) of Section 101315. The department may withhold quarterly payments of moneys to a local health jurisdiction if the local health jurisdiction is not in compliance with this article or the terms of that local health jurisdiction's plan as approved by the department. Before any funds are recouped or withheld from a local health jurisdiction, the department shall meet with local health officials to discuss the status of the unspent moneys or the disputed use of the funds, or both.

(j) Notwithstanding any other provision of law, moneys made available for bioterrorism preparedness pursuant to this article in the 2001–02 fiscal year shall be available for expenditure and encumbrance until June 30, 2003. Moneys made available for bioterrorism preparedness pursuant to this article from July 1, 2002, to August 30, 2003, inclusive, shall be available for expenditure and encumbrance until August 30, 2004. Moneys made available in the 2003–04 Budget Act for bioterrorism preparedness shall be available for expenditure and encumbrance until August 30, 2005.

SEC. 1.4. Section 120955 of the Health and Safety Code is amended to read:

120955. (a) (1) To the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, the director shall establish and may administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immune deficiency syndrome (AIDS). If the director makes a formal determination that, in any fiscal year, funds appropriated for the program will be insufficient to provide all of those drug treatments to existing eligible persons for the fiscal year and that a suspension of the implementation of the program is necessary, the director may suspend eligibility determinations and enrollment in the program for the period of time necessary to meet the needs of existing eligible persons in the program.

(2) The director shall develop, maintain, and update as necessary a list of drugs to be provided under this program.

(b) The director may grant funds to a county public health department through standard agreements to administer this program in that county. To maximize the recipients' access to drugs covered by this program, the director shall urge the county health department in counties granted these funds to decentralize distribution of the drugs to the recipients.

(c) The director shall establish a rate structure for reimbursement for the cost of each drug included in the program. Rates shall not be less than the actual cost of the drug. However, the director may purchase a listed drug directly from the manufacturer and negotiate the most favorable bulk price for that drug.

(d) Manufacturers of the drugs on the list shall pay the department a rebate equal to the rebate that would be applicable to the drug under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) plus an additional rebate to be negotiated by each manufacturer with the department, except that no rebates shall be paid to the department under this section on drugs for which the department has received a rebate under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) or that have been purchased on behalf of county health departments or other eligible entities at discount prices made available under Section 256b of Title 42 of the United States Code.

(e) The department shall submit an invoice, not less than two times per year, to each manufacturer for the amount of the rebate required by subdivision (d).

(f) Drugs may be removed from the list for failure to pay the rebate required by subdivision (d), unless the department determines that removal of the drug from the list would cause substantial medical hardship to beneficiaries.

(g) The department may adopt emergency regulations to implement amendments to this chapter made during the 1997–98 Regular Session, in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days.

(h) Reimbursement under this chapter shall not be made for any drugs that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except that the director may authorize an exemption from this subdivision where exemption would represent a cost savings to the state.

(i) The department may also subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with existing non-ADAP drug coverage by paying for

prescription drugs included on the ADAP formulary within the existing ADAP operational structure up to, but not exceeding, the amount of that cost-sharing obligation. This cost sharing may only be applied in circumstances in which the other payer recognizes the ADAP payment as counting toward the individual's cost-sharing obligation.

SEC. 2. Section 123929 is added to the Health and Safety Code, to read:

123929. (a) Except as otherwise provided in this section and Section 14133.05 of the Welfare and Institutions Code, California Children's Services Program services provided pursuant to this article require prior authorization by the department or its designee. Prior authorization is contingent on determination by the department or its designee of all of the following:

(1) The child receiving the services is confirmed to be medically eligible for the CCS program.

(2) The provider of the services is approved in accordance with the standards of the CCS program.

(3) The services authorized are medically necessary to treat the child's CCS-eligible medical condition.

(b) Effective July 1, 2004, the department or its designee may approve a request for a treatment authorization that is otherwise in conformance with subdivision (a) for services for a child participating in the Healthy Families Program pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code, received by the department or its designee after the requested treatment has been provided to the child.

(c) Effective July 1, 2004, if a provider of services who meets the requirements of paragraph (2) of subdivision (a) incurs costs for services described in paragraph (3) of subdivision (a) to treat a child described in subdivision (b) who is subsequently determined to be medically eligible for the CCS program as determined by the department or its designee, the department may reimburse the provider for those costs. Reimbursement under this section shall conform to the requirements of Section 14105.18 of the Welfare and Institutions Code.

SEC. 3. Section 12693.325 of the Insurance Code is amended to read:

12693.325. (a) (1) Notwithstanding any provision of this chapter, a participating health, dental, or vision plan that is licensed and in good standing as required by subdivision (b) of Section 12693.36 may provide application assistance directly to an applicant acting on behalf of an eligible person who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.

(2) A participating health, dental, or vision plan may also provide application assistance directly to an applicant only under the following conditions:

(A) The assistance is provided upon referral from a government agency, school, or school district.

(B) The applicant has authorized the government agency, school, or school district to allow a health, dental, or vision plan to contact the applicant with additional information on enrolling in free or low-cost health care.

(C) The State Department of Health Services approves the applicant authorization form in consultation with the board.

(D) The plan may not actively solicit referrals and may not provide compensation for the referrals.

(E) If a family is already enrolled in a health plan, the plan that contacts the family cannot encourage the family to change health plans.

(F) The board amends its marketing guidelines to require that when a government agency, school, or school district requests assistance from a participating health, dental, or vision plan to provide application assistance, that all plans in the area shall be invited to participate.

(G) The plan abides by the board's marketing guidelines.

(b) A participating health, dental, or vision plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:

(1) The child is enrolled in a Medi-Cal managed care plan and the participating plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.

(2) The child is enrolled in a Healthy Families Program managed care plan and the participating plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for the Healthy Families Program. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.

(3) The participating plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(5) The child's family, but not the child, is participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(c) A participating health, dental, or vision plan employee or other representative that provides application assistance shall complete a certified application assistant training class approved by the State Department of Health Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgment from the applicant that the information was provided.

(d) A participating health, dental, or vision plan that provides application assistance may not do any of the following:

(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or telephone solicitation.

(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.

(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.

(e) A participating health, dental, or vision plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.

(f) A participating health, dental, or vision plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.

(g) Each participating health, dental, or vision plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Services.

(h) Each participating health, dental, or vision plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.

(i) When deemed appropriate by the board, the board may refer a participating health, dental, or vision plan to the Department of Managed Health Care or the State Department of Health Services, as applicable, for the review or investigation of its application assistance practices.

(j) The board shall evaluate the impact of the changes required by this section and shall provide a biennial report to the Legislature on or before March 1 of every other year. To prepare these reports, the State

Department of Health Services, in cooperation with the board, shall code all the application packets used by a managed care plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's Web site. In addition, the board shall periodically survey those families assisted by plans to determine if the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health, dental, or vision plans available to them.

(k) Nothing in this section shall be seen as mitigating a participating health, dental, or vision plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States Code.

(l) Paragraph (2) of subdivision (a) shall become inoperative on January 1, 2006.

SEC. 4. Section 12693.36 of the Insurance Code is amended to read:

12693.36. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care, as the case may be.

(b) Participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Managed Health Care shall be licensed and in good standing with their respective licensing agencies. In their application to the program, those entities shall provide assurance of their standing with the appropriate licensing entity.

SEC. 4.5. Section 12693.50 is added to the Insurance Code, to read:

12693.50. (a) The board shall consult and coordinate with the State Department of Health Services to implement the Medi-Cal to Healthy Families Accelerated Enrollment program pursuant to Section 14011.65 of the Welfare and Institutions Code.

(b) The state shall seek approval of any amendments to the state plan, necessary to implement Section 14011.65 of the Welfare and Institutions Code in accordance with Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.). Notwithstanding any other provision of law, only when all necessary federal approvals have been obtained shall Section 14011.65 of the Welfare and Institutions Code be implemented.

(c) The board may adopt emergency regulations to implement the provision of accelerated eligibility benefits pursuant to this section and as described under Section 14011.65 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to, regulations that implement any changes in rules relating to program eligibility, enrollment, and disenrollment. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency

regulations and one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations, and each shall remain in effect for no more than 180 days.

SEC. 5. Section 12699.52 of the Insurance Code is amended to read:

12699.52. (a) The County Health Initiative Matching Fund is hereby created within the State Treasury. The fund shall accept intergovernmental transfers as follows:

(1) The nonfederal matching fund requirement for federal financial participation through the State Children’s Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code).

(2) Funding associated with a proposal approved pursuant to subdivision (g) of Section 12699.53.

(b) Amounts deposited in the fund shall be used only for the purposes specified by this part.

(c) The board shall administer this fund and the provisions of this part in collaboration with the State Department of Health Services for the express purpose of allowing local funds to be used to facilitate increasing the state’s ability to utilize federal funds available to California and for costs associated with a proposal pursuant to subdivision (g) of Section 12699.53. Federal funds shall be used prior to the expiration of their authority for programs designed to improve and expand access for uninsured persons.

(d) The board shall authorize the expenditure of money in the fund to cover program expenses, including cost to the state to administer the program.

SEC. 6. Section 12699.53 of the Insurance Code is amended to read:

12699.53. (a) An applicant that will provide an intergovernmental transfer may submit a proposal to the board for funding for the purpose of providing comprehensive health insurance coverage to any child or adult who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, and in case of a child, whose family income is at or below 300 percent of the federal poverty level, or in case of an adult, whose family income does not exceed 200 percent of the federal poverty level, in specific geographic areas, as published quarterly in the Federal Register by the Department of Health and Human Services, and which child or adult does not qualify for either the Healthy Families Program (Part 6.2 (commencing with Section 12693) or Medi-Cal with no share of cost pursuant to the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(b) The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of any applicable approved federal waiver or state plan amendment as well as the board’s requirements for the sound operation of the proposed project, and shall, on an annual basis, either commit to fully

funding the necessary intergovernmental amount or withdraw from the program. The board may identify specific geographical areas that, in comparison to the national level, have a higher cost of living or housing or a greater need for additional health services, using data obtained from the most recent federal census, the federal Consumer Expenditure Survey, or from other sources. The proposal may include an administrative mechanism for outreach and eligibility.

(c) The applicant may include in its proposal reimbursement of medical, dental, vision, or mental health services delivered to children who are eligible under the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code), if these services are part of an overall program with the measurable goal of enrolling served children in the Healthy Families Program.

(d) If a child is determined to be eligible for benefits for the treatment of an eligible medical condition under the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the health, dental, or vision plan providing services to the child pursuant to this part shall not be responsible for the provision of, or payment for, those authorized services for that child. The proposal from an applicant shall contain provisions to ensure that a child whom the health, dental, or vision plan reasonably believes would be eligible for services under the California Children's Services Program is referred to that program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program and approved by the California Children's Services Program. All other services provided under the proposal from the applicant shall be made available pursuant to this part to a child who is eligible for services under the California Children's Services Program.

(e) An applicant may submit a proposal for reimbursement of medical, dental, or vision services delivered to adults as specified in subdivision (a).

(f) (1) If a proposal from an applicant for coverage of an adult includes state funds or funds derived from county sources, the applicant shall, to the extent feasible, include participation by health care service plans licensed by the Department of Managed Health Care or health insurers regulated by the Department of Insurance that contract with the board to provide services to Healthy Families Program subscribers in the geographic area.

(2) This subdivision shall not apply if the population to be served by the applicant's proposal is less than 1,000 persons.

(g) Notwithstanding any other provision of this section, an applicant may submit a proposal to the board for the purposes of providing comprehensive health insurance coverage to children whose coverage is not eligible for funding under Title XXI of the Social Security Act, or to a

combination of children whose coverage is eligible for funding under Title XXI of the Social Security Act and children whose coverage is not eligible for that funding. To be approved by the board, these proposals shall comply with both of the following requirements:

(1) Meet all applicable requirements for funding under this part, except for availability of funding through Title XXI of the Social Security Act.

(2) Provide for the administration of children's coverage by the board through the administrative infrastructure serving the Healthy Families Program, and through health, dental, and vision plans serving the Healthy Families Program.

SEC. 7. Section 12699.54 of the Insurance Code is amended to read:

12699.54. (a) The board, in consultation with the State Department of Health Services, the Healthy Families Advisory Committee, and other appropriate parties, shall establish the criteria for evaluating an applicant's proposal, which shall include, but not be limited to, the following:

(1) The extent to which the program described in the proposal provides comprehensive coverage including health, dental, and vision benefits.

(2) Whether the proposal includes a promotional component to notify the public of its provision of health insurance to eligible children.

(3) The simplicity of the proposal's procedures for applying to participate and for determining eligibility for participation in its program.

(4) The extent to which the proposal provides for coordination and conformity with benefits provided through Medi-Cal and the Healthy Families Program.

(5) The extent to which the proposal provides for coordination and conformity with existing Healthy Families Program administrative entities in order to prevent administrative duplication and fragmentation.

(6) The ability of the health care providers designated in the proposal to serve the eligible population and the extent to which the proposal includes traditional and safety net providers, as defined in regulations adopted pursuant to the Healthy Families Program.

(7) For children's coverage, the extent to which the proposal intends to work with the school districts and county offices of education.

(8) The total amount of funds available to the applicant to implement the program described in its proposal, and the percentage of this amount proposed for administrative costs as well as the cost to the state to administer the proposal.

(9) The extent to which the proposal seeks to minimize the substitution of private employer health insurance coverage for health benefits provided through a governmental source.

(10) The extent to which local resources may be available after the depletion of federal funds to continue any current program expansions for persons covered under local health care financing programs or for expanded benefits.

(11) For coverage proposals for adults, the extent to which the proposal seeks to pursue assistance from employers in the payment of premiums

and whether the proposal requires, as a condition of parental enrollment, the enrollment of children in the applicant's plan or a competing plan.

(12) For coverage proposals for adults, the extent to which the proposal offers subscribers a choice of health care service plans or health insurers similar to the choices available to children eligible for the Healthy Families Program in that county.

(13) For the purposes of defining an applicant's eligibility for funding under this part, the following shall apply:

(A) The same income methodology shall be used for the proposed program that is currently used for the Medi-Cal and the Healthy Families programs.

(B) Only participating licensed Healthy Families dental, health, and vision plans may be used. However, the board may permit exceptions to this requirement consistent with the purpose, of this part.

(b) The board may, in its sole discretion, approve or disapprove projects for funding pursuant to this part on an annual basis.

(c) To the extent that an applicant's proposal pursuant to this part provides for health plan or administrative services under a contract entered into by the board or at rates negotiated for the applicant by the board, a contract entered into by the board or by an applicant shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services to the same extent as contracts entered into pursuant to Part 6.2 (commencing with Section 12693). The board and the applicant shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriated for the project including family contributions.

SEC. 8. Section 12699.56 of the Insurance Code is amended to read:

12699.56. (a) Upon its approval of a proposal that shall include any allowable amount of federal funds under the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code), the board, in collaboration with the State Department of Health Services, may provide the applicant reimbursement in an amount equal to the amount that the applicant will contribute to implement the program described in its proposal, plus the appropriate and allowable amount of federal funds. Not more than 10 percent of the County Health Initiative Matching Fund and matching federal funds shall be expended in any one fiscal year for administrative costs, including the costs to the state to administer the proposal, unless the board permits the expenditure consistent with the availability of federal matching funds not needed for the purposes described in paragraph (3) of subdivision (a) of Section 12699.62, or unless the board determines that an expenditure for administrative costs has no impact on available federal funding. The board, in collaboration with the State Department of Health Services, may audit the expenses incurred by the applicant in implementing its program to ensure that the

expenditures comply with the provisions of this part. No reimbursement may be made to an applicant that fails to meet its financial participation obligation under this part. The state's reasonable startup costs and ongoing costs for administering the program shall be reimbursed by those entities applying for funding.

(b) Any program approved pursuant to subdivision (g) of Section 12699.53 that requires any funding not allowable for a federal match under the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) shall provide the board with the total amount of funds needed to provide that portion of coverage not eligible for federal matching funds, including reasonable startup costs and ongoing costs for administering the program.

(c) Each applicant that is provided funds under this part shall submit to the board a plan to limit initial and continuing enrollment in its program in the event the amount of moneys for its program is insufficient to maintain health insurance coverage for those participating in the program.

SEC. 9. Section 12699.57 of the Insurance Code is amended to read:

12699.57. Each health care service plan, specialized health care service plan, and health insurer that contracts to provide health care benefits under this part shall be licensed by the Department of Managed Health Care or the Department of Insurance.

SEC. 10. Section 12699.59 of the Insurance Code is amended to read:

12699.59. All expenses incurred by the board and the State Department of Health Services in administering this part, including, but not limited to, expenses for developing standards and processes to implement any of the provisions of this part, evaluating applications, or processing or granting appeals growing out of any of the provisions of this part, shall be paid from the fund or directly by applicants, except that the board may accept funding from a not-for-profit group or foundation, or from a governmental entity providing grants for health-related activities, to administer this part.

SEC. 11. Section 12699.63 of the Insurance Code is amended to read:

12699.63. The state shall be held harmless for any federal disallowance resulting from this part and any other expenses or liabilities, including, but not limited to, the cost of processing or granting appeals. An applicant receiving supplemental reimbursement pursuant to this part shall be liable for any reduced federal financial participation, and any other expenses or liabilities, including, but not limited to, the costs of processing or granting appeals, resulting from the implementation of this part with respect to that applicant. The state may recoup any federal disallowance from the applicant.

SEC. 12. Section 4643 of the Welfare and Institutions Code is amended to read:

4643. (a) If assessment is needed, prior to July 1, 2006, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to

unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b). On and after July 1, 2006, the assessment shall be performed within 60 days following intake and if unusual circumstances prevent the completion of assessment within 60 days following intake, this assessment period may be extended by one 30-day period with the advance written approval of the department.

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

SEC. 13. Section 4648.4 of the Welfare and Institutions Code is amended to read:

4648.4. Notwithstanding any other provision of law or regulation, during the 2005-06 fiscal year, no regional center may pay any provider of the following services or supports a rate that is greater than the rate that is in effect on or after June 30, 2004, unless the increase is required by a contract between the regional center and the vendor that is in effect on June 30, 2004, or the regional center demonstrates that the approval is necessary to protect the consumer's health or safety and the department has granted prior written authorization:

- (a) Supported living services.
- (b) Transportation, including travel reimbursement.
- (c) Socialization training programs.
- (d) Behavior intervention training.
- (e) Community integration training programs.
- (f) Community activities support services.
- (g) Mobile day programs.
- (h) Creative art programs.
- (i) Supplemental day services program supports.
- (j) Adaptive skills trainers.
- (k) Independent living specialists.

SEC. 14. Section 4681.5 of the Welfare and Institutions Code is amended to read:

4681.5. Notwithstanding any other provision of law or regulation, during the 2005-06 fiscal year, no regional center may approve any service level for a residential service provider, as defined in Section 56005 of Title 17 of the California Code of Regulations, if the approval would result in an increase in the rate to be paid to the provider that is greater than the rate

that is in effect on or after June 30, 2005, unless the regional center demonstrates to the department that the approval is necessary to protect the consumer's health or safety and the department has granted prior written authorization.

SEC. 15. Section 4685.5 of the Welfare and Institutions Code is repealed.

SEC. 15.5. Section 4685.7 is added to the Welfare and Institutions Code, to read:

4685.7. (a) Contingent upon approval of a federal waiver, the Self-Directed Services Program (SDS Program) is hereby established and shall be available in every regional center catchment area to provide participants, within an individual budget, greater control over needed services and supports. The Self-Directed Services Program shall be consistent with the requirements set forth in this section. In order to provide opportunities to participate in the program, the department shall adopt regulations, consistent with federal law, to implement the procedures set forth in this section.

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

(1) "Financial management services" means a service or function that assists the participant to manage and direct the distribution of funds contained in the individual budget. This may include, but is not limited to, bill paying services and activities that facilitate the employment of service workers by the participant, including, but not limited to, federal, state, and local tax withholding payments, unemployment compensation fees, setting of wages and benefits, wage settlements, fiscal accounting, and expenditure reports. The department shall establish specific qualifications which shall be required of a financial management services provider.

(2) "Supports brokerage" means a service or function that assists participants in making informed decisions about the individual budget, and assists in locating, accessing and coordinating services consistent with and reflecting a participant's needs and preferences. The service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, participating in the person-centered planning process and development of the individual program plan, and obtaining identified supports and services.

(3) "Supports broker" means a person, selected and directed by the participant, who fulfills the supports brokerage service or function and assists the participant in the SDS Program. Specific qualifications shall be established by the department and required of a supports broker provider.

(4) "Waiver" means a waiver of federal law pursuant to Section 1396n of Title 42 of the United States Code.

(5) "Independence Plus Self-Directed (IPSD) Waiver Program" or "Self-Directed Waiver Program" means a federal waiver to the state's Medicaid plan to allow a person with developmental disabilities who needs or requires long-term supports and services, and when appropriate, the person's family, greater opportunity to control his or her own health and well-being by utilization of self-directed services.

(6) “Self-directed services” or “SDS” means a voluntary delivery system consisting of a defined and comprehensive mix of services and supports, selected and directed by a participant, in order to meet all or some of the objectives in his or her individual program plan. Self-directed services are designed to assist the participant to achieve personally defined outcomes in inclusive community settings.

Self-directed services shall include, but are not limited to, all of the following:

- (A) Home health aide services.
- (B) Supported employment and prevocational services.
- (C) Respite services.
- (D) Supports broker functions and services.
- (E) Financial management services and functions.
- (F) Environmental accessibility adaptations.
- (G) Skilled nursing.
- (H) Transportation.
- (I) Specialized medical equipment and supplies.
- (J) Personal emergency response system.
- (K) Integrative therapies.
- (L) Vehicle adaptations.
- (M) Communication support.
- (N) Crises intervention.
- (O) Nutritional consultation.
- (P) Behavior intervention services.
- (Q) Specialized therapeutic services.
- (R) Family assistance and support.
- (S) Housing access supports.
- (T) Community living supports, including, but not limited to, socialization, personal skill development, community participation, recreation, leisure, home and personal care.
- (U) Advocacy services.
- (V) Individual training and education.
- (W) Participant-designated goods and services.
- (X) Training and education transition services.

The department shall include all of the services and supports listed in this paragraph in the IPSD Waiver Program application. Notwithstanding this paragraph, only services and supports included in an approved IPSD Waiver shall be funded through the SDS Program.

(7) “Advocacy services” means services and supports that facilitate the participant in exercising his or her legal, civil and service rights to gain access to generic services and benefits that the participant is entitled to receive. Advocacy services shall only be provided when other sources of similar assistance are not available to the participant, and when advocacy is directed towards obtaining generic services.

(8) “Individual budget” means the amount of funding available to the participant for the purchase of services and supports necessary to

implement an individual program plan. The individual budget shall be constructed using a fair, equitable, and transparent methodology.

(9) “Risk pool” means an account that is available for use in addressing the unanticipated needs of participants in the SDS Program.

(10) “Participant” means an individual, and when appropriate, his or her parents, legal guardian or conservator, or authorized representative, who have been deemed eligible for, and have voluntarily agreed to participate in, the SDS Program.

(c) Participation in the SDS Program is fully voluntary. A participant may choose to participate in, and may choose to leave, the SDS Program at any time. A regional center may not require participation in the SDS Program as a condition of eligibility for, or the delivery of, services and supports otherwise available under this Division.

(d) The department shall develop informational materials about the SDS Program. The department shall ensure that regional centers are trained in the principles of SDS, the mechanics of the SDS Program and the rights of consumers and families as candidates for, and participants, in the SDS Program. Regional centers shall conduct local meetings or forums to provide regional center consumers and families with information about the SDS Program. All consumers and families who express an interest in participating in the SDS program shall receive an in-depth orientation, conducted by the regional center, prior to enrollment in the program.

(e) Prior to enrollment in the SDS Program, and based on the methodologies described below, an individual, and when appropriate, his or her parents, legal guardian or conservator, or authorized representative, shall be provided in writing two individual budget amounts. If the individual, and when appropriate his parents, legal guardian or conservator, or authorized representative, elects to become a participant in the SDS Program, he or she shall choose which of the two budget amounts provided will be used to implement their individual program plan.

(1) The methodologies and formulae for determining the two individual budget amounts shall be detailed in departmental regulations, as follows:

(A) One individual budget amount shall equal 90 percent of the annual purchase of services costs for the individual. The annual costs shall reflect the average annual costs for the previous two fiscal years for the individual.

(B) One individual budget amount shall equal 90 percent of the annual per capita purchase of service costs for the previous two fiscal years for consumers with similar characteristics, who do not receive services through the SDS Program, based on factors including, but not limited to, age, type of residence, type of disability and ability, functional skills, and whether the individual is in transition. This budget methodology shall be constructed using data available on the State Department of Developmental Services information system.

(2) Once a participant has selected an individual budget amount, that individual budget amount shall be available to the participant each year for the purchase of self-directed services until a new individual budget amount

has been determined. An individual budget amount shall be calculated no more than once in a 12-month period.

(3) As determined by the participant, the individual budget shall be distributed among the following budget categories in order to implement the IPP:

- (A) Community Living.
- (B) Health and Clinical Services.
- (C) Employment.
- (D) Training and Education.
- (E) Environment and Medical Supports.
- (F) Transportation.

(4) Annually, participants may transfer up to 10 percent of the funds originally distributed to any budget category set forth in paragraph (3), to another budget category or categories. Transfers in excess of 10 percent of the original amount allocated to any budget category may be made upon the approval of the regional center. Regional centers may only deny a transfer if necessary to protect the health and safety of the participant.

(5) The regional center shall annually ascertain from the participant whether there are any circumstances that require a change to the annual individual budget amount. The department shall detail in regulations the process by which this annual review shall be achieved.

(6) A regional center's calculation of an individual budget amount may be appealed to the executive director of the regional center, or his or her designee, within 30 days after receipt of the budget amount. The executive director shall issue a written decision within 10 working days. The decision of the executive director may be appealed to the Director of Developmental Services, or his or her designee, within 15 days of receipt of the written decision. The decision of the department is final.

(f) The department shall establish a risk pool fund to meet the unanticipated needs of participants in the SDS Program. The fund shall be administered by the department. Notwithstanding Section 13340 of the Government Code, all moneys in the fund shall be continuously appropriated to the department, without regard to fiscal years, for the purpose of funding services and supports pursuant to this subdivision.

(1) The risk pool shall be funded at the equivalent of 5 percent of the historic annual purchase of service costs for consumers participating in the SDS Program.

(2) The risk pool shall be allocated by the department to regional centers through a process specified by the department.

(3) The risk pool may be used only in the event of substantial change in a participant's service and support needs that were not known at the time the individual budget was set, including an urgent need to relocate a residence, and catastrophic injury or illness.

(4) The risk pool may be accessed by a participant more than once in a lifetime.

(g) In the first year of the SDS Program, the department shall provide for establishment of savings to the General Fund equivalent to 5 percent of

the historic annual purchase of service costs for SDS program participants. In subsequent fiscal years, the department shall annually provide for establishment of savings to the General Fund equivalent to 5 percent of the annual purchase of services costs for SDS Program participants, averaged over the prior two fiscal years.

(h) A regional center may advance funds to a financial management services entity pursuant to SDS Program regulations to facilitate development of a participant's individual budget and transition into the SDS Program.

(i) Participation in the SDS Program shall be available to any regional center consumer who meets the following eligibility requirements.

(1) The participant is three years of age or older.

(2) The participant has a developmental disability, as defined in Section 4512.

(3) The participant does not live in a licensed long-term health care facility, as defined in paragraph (44) of subdivision (a) of Section 54302 of Title 17 of the California Code of Regulations, or a residential facility, as defined in paragraph (55) of subdivision (a) of Section 54302 of Title 17 of the California Code of Regulations, or receive day program or habilitation services, as defined in paragraph (16) or (34) of subdivision (a) of Section 54302 of Title 17 of the California Code of Regulations, respectively. An individual, and when appropriate, his or her parent, legal guardian or conservator, or authorized representative, who is not eligible to participate in the SDS Program pursuant to this paragraph, may request that the regional center provide person-centered planning services in order to make arrangements for transition to the SDS Program. In that case, the regional center shall initiate person-centered planning services within 60 days of a request.

(4) The participant agrees to all of the following terms and conditions:

(A) The participant shall undergo an in-depth orientation to the SDS Program prior to enrollment.

(B) The participant shall agree to utilize the services and supports available within the SDS Program only when generic services cannot be accessed, and except for Medi-Cal state plan benefits when applicable.

(C) The participant shall consent to use only services necessary to implement his or her individual program plan as described in the IPSD Waiver Program, and as defined in paragraph (6) of subdivision (b), as an available service in the SDS Program, and shall agree to comply with any and all other terms and conditions for participation in the SDS Program described in this section.

(D) The participant shall manage self-directed services within the individual budget amount, chosen pursuant to subdivision (e).

(E) The participant shall utilize the services of a financial management services entity of his or her own choosing. A financial management services provider may either be hired or designated by the participant. A designated financial management services provider shall perform services on a nonpaid basis. An individual or a parent of an individual in the SDS

Program shall provide financial management services only as a designated provider and only if the capacity to fulfill the roles and responsibilities as described in the financial management services provider qualifications can be demonstrated to the regional center.

(F) The participant shall utilize the services of a supports broker of his or her own choosing for the purpose of providing services and functions as described in paragraphs (2) and (3) of subdivision (b). A supports broker may either be hired or designated by the participant. A designated supports broker shall perform support brokerage services on a nonpaid basis. An individual or a parent of an individual in the SDS Program shall provide supports brokerage services or his or her designated representative shall provide the services only as a designated provider and only if the capacity to fulfill the role and responsibilities as described in the supports broker provider qualifications can be demonstrated to the financial management services entity.

(j) A participant who is not Medi-Cal eligible may participate in the SDS Program without IPSP Waiver Program enrollment and receive self-directed services if all other IPSP Waiver Program eligibility requirements are met.

(k) The planning team, established pursuant to subdivision (j) of Section 4512, shall utilize the person-centered planning process to develop the Individual Program Plan (IPP) for an SDS participant. The IPP shall detail the goals and objectives of the participant that are to be met through the purchase of participant selected services and supports.

(l) The participant shall implement his or her IPP, including choosing the services and supports allowable under this section necessary to implement the plan. A regional center may not prohibit the purchase of any service or support that is otherwise allowable under this section.

(m) An adult may designate an authorized representative to effect the implementation. The representative shall meet all of the following requirements:

(1) He or she shall demonstrate knowledge and understanding of the participant's needs and preferences.

(2) He or she shall be willing and able to comply with SDS Program requirements.

(3) He or she shall be at least 18 years of age.

(4) He or she shall be approved by the participant to act in the capacity of a representative.

(n) The participant, or his or her authorized representative and the regional center case manager shall receive a monthly budget statement that describes the amount of funds allocated by budget category, the amount spent in the previous 30-day period, and the amount of funding that remains available under the participant's individual budget.

(o) If at any time during participation in the SDS Program a regional center determines that an individual is no longer eligible to continue based on the criteria described in subdivision (i), or a participant voluntarily chooses to exit the SDS Program, the regional center shall provide for the

participant's transition from the SDS Program to other services and supports. This shall include the development of a new individual program plan that reflects the services and supports necessary to meet the individual's needs. The regional center shall ensure that there is no gap in services and supports during the transition period.

(1) Upon determination of ineligibility pursuant to this subdivision, the regional center shall inform the participant in writing of his or her ineligibility, the reason for the determination of ineligibility and shall provide a written notice of the fair hearing rights, as required by Section 4701.

(2) An individual determined ineligible, or who voluntarily exits the SDS Program, shall be permitted to return to the SDS Program upon meeting all applicable eligibility criteria and after a minimum of 12 months time has elapsed.

(p) A participant in the SDS Program shall have all the rights established in Chapter 7 (commencing with Section 4700), except as provided under paragraph (6) of subdivision (e).

(q) Only a financial management services provider is required to apply for vendorization in accordance with Subchapter 2 (commencing with Section 54300) of Chapter 3 of Title 17 of the California Code of Regulations, for the SDS Program. All other service providers shall have applicable state licenses, certifications, or other state required documentation, but are exempt from the vendorization requirements set forth in Title 17 of the California Code of Regulations. The financial management services entity shall ensure and document that all service providers meet specified requirements for any service that may be delivered to the participant.

(r) A participant in the SDS Program may request, at no charge to the participant or the regional center, criminal history background checks for persons seeking employment as a service provider and providing direct care services to the participant.

(1) Criminal history records checks pursuant to this subdivision shall be performed and administered as described in subdivision (b) and subdivisions (d) to (h), inclusive, of Section 4689.2, and Sections 4689.4 to 4689.6, inclusive, and shall apply to vendorization of providers and hiring of employees to provide services for family home agencies and family homes.

(2) The department may enter into a written agreement with the Department of Justice to implement this subdivision.

(s) A participant enrolled in the SDS Program pursuant to this section and utilizing an individual budget for services and supports is exempt from Section 4783 and from the Family Cost Participation Program.

(t) Notwithstanding any provision of law, an individual receiving services and supports under the self-determination projects established pursuant to Section 4685.5 may elect to continue to receive self-determination services within his or her current scope and existing procedures and parameters. Participation in a self-determination project

pursuant to Section 4685.5 may only be terminated upon a participant's voluntary election and qualification to receive services under another delivery system.

(u) Each regional center shall be responsible for implementing an SDS Program as a term of its contract under Section 4629.

(v) Commencing January 10, 2008, the department shall annually provide the following information to the policy and fiscal committees of the Legislature:

- (1) Number and characteristics of participants, by regional center.
- (2) Types and ranking of services and supports purchased under the SDS Program, by regional center.
- (3) Range and average of individual budgets, by regional center.
- (4) Utilization of the risk pool, including range and average individual budget augmentations and type of service, by regional centers.
- (5) Information regarding consumer satisfaction under the SDS Program and, when data is available, the traditional service delivery system, by regional center.
- (6) The proportion of participants who report that their choices and decisions are respected and supported.
- (7) The proportion of participants who report they are able to recruit and hire qualified service providers.
- (8) The number and outcome of individual budget appeals, by regional center.
- (9) The number and outcome of fair hearing appeals, by regional center.
- (10) The number of participants who voluntarily withdraw from participation in the SDS Program and a summary of the reasons why, by regional center.
- (11) The number of participants who are subsequently determined to no longer be eligible for the SDS Program and a summary of the reasons why, by regional center.
- (12) Identification of barriers to participation and recommendations for program improvements.
- (13) A comparison of average annual expenditures for individuals with similar characteristics not participating in the SDS Program.

SEC. 16. Section 4691.6 of the Welfare and Institutions Code is amended to read:

4691.6. (a) Notwithstanding any other provision of law or regulation, during the 2005-06 fiscal year, the department may not establish any permanent payment rate for a community-based day program or in-home respite service agency provider that has a temporary payment rate in effect on June 30, 2005, if the permanent payment rate would be greater than the temporary payment rate in effect on or after June 30, 2005, unless the regional center demonstrates to the department that the permanent payment rate is necessary to protect the consumers' health or safety.

(b) Notwithstanding any other provision of law or regulation, during the 2005-06 fiscal year, neither the department nor any regional center may approve any program design modification or revendorization for a

community-based day program or in-home respite service agency provider that would result in an increase in the rate to be paid to the vendor from the rate that is in effect on or after June 30, 2005, unless the regional center demonstrates that the program design modification or revendorization is necessary to protect the consumers' health or safety and the department has granted prior written authorization.

(c) Notwithstanding any other provision of law or regulation, during the 2005-06 fiscal year, the department may not approve an anticipated rate adjusted for a community-based day program or in-home respite service agency provider that would result in an increase in the rate to be paid to the vendor from the rate that is in effect on or after June 30, 2005, unless the regional center demonstrates that the anticipated rate adjustment is necessary to protect the consumers' health or safety.

(d) Notwithstanding any other provision of law or regulation, during the 2005-06 fiscal year, the department may not approve any rate adjustment for a habilitation services program that would result in an increase in the rate to be paid to the vendor from the rate that is in effect on or after June 30, 2005, unless the regional center demonstrates that the rate adjustment is necessary to protect the consumers' health and safety and the department has granted prior written authorization.

SEC. 17. Section 4781.5 of the Welfare and Institutions Code is amended to read:

4781.5. For the 2005-06 fiscal year only, a regional center may not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the department has granted prior written authorization for the expenditure. This provision shall not apply to any of the following:

(a) The purchase of services funds allocated as part of the department's community placement plan process.

(b) Expenditures for the startup of new programs made pursuant to a contract entered into before July 1, 2002.

SEC. 18. Section 4851 of the Welfare and Institutions Code is amended to read:

4851. The definitions contained in this chapter shall govern the construction of this chapter, with respect to habilitation services provided through the regional center, and unless the context requires otherwise, the following terms shall have the following meanings:

(a) "Habilitation services" means community-based services purchased or provided for adults with developmental disabilities, including services provided under the Work Activity Program and the Supported Employment Program, to prepare and maintain them at their highest level of vocational functioning, or to prepare them for referral to vocational rehabilitation services.

(b) "Individual program plan" means the overall plan developed by a regional center pursuant to Section 4646.

(c) “Individual habilitation service plan” means the service plan developed by the habilitation service vendor to meet employment goals in the individual program plan.

(d) “Department” means the State Department of Developmental Services.

(e) “Work activity program” includes, but is not limited to, sheltered workshops or work activity centers, or community-based work activity programs certified pursuant to subdivision (f) or accredited by CARF, the Rehabilitation Accreditation Commission.

(f) “Certification” means certification procedures developed by the Department of Rehabilitation.

(g) “Work activity program day” means the period of time during which a Work Activity Program provides services to consumers.

(h) “Full day of service” means, for purposes of billing, a day in which the consumer attends a minimum of the declared and approved work activity program day, less 30 minutes, excluding the lunch period.

(i) “Half day of service” means, for purposes of billing, any day in which the consumer’s attendance does not meet the criteria for billing for a full day of service as defined in subdivision (g), and the consumer attends the work activity program not less than two hours, excluding the lunch period.

(j) “Supported employment program” means a program that meets the requirements of subdivisions (n) to (s), inclusive.

(k) “Consumer” means any adult who receives services purchased under this chapter.

(l) “Accreditation” means a determination of compliance with the set of standards appropriate to the delivery of services by a work activity program or supported employment program, developed by CARF, the Rehabilitation Accreditation Commission, and applied by the commission or the department.

(m) “CARF” means CARF the Rehabilitation Accreditation Commission.

(n) “Supported employment” means paid work that is integrated in the community for individuals with developmental disabilities.

(o) “Integrated work” means the engagement of an employee with a disability in work in a setting typically found in the community in which individuals interact with individuals without disabilities other than those who are providing services to those individuals, to the same extent that individuals without disabilities in comparable positions interact with other persons.

(p) “Supported employment placement” means the employment of an individual with a developmental disability by an employer in the community, directly or through contract with a supported employment program. This includes provision of ongoing support services necessary for the individual to retain employment.

(q) “Allowable supported employment services” means the services approved in the individual program plan and specified in the individual

habilitation service plan for the purpose of achieving supported employment as an outcome, and may include any of the following:

- (1) Job development, to the extent authorized by the regional center.
- (2) Program staff time for conducting job analysis of supported employment opportunities for a specific consumer.
- (3) Program staff time for the direct supervision or training of a consumer or consumers while they engage in integrated work unless other arrangements for consumer supervision, including, but not limited to, employer supervision reimbursed by the supported employment program, are approved by the regional center.
- (4) Community-based training in adaptive functional and social skills necessary to ensure job adjustment and retention.
- (5) Counseling with a consumer's significant other to ensure support of a consumer in job adjustment.
- (6) Advocacy or intervention on behalf of a consumer to resolve problems affecting the consumer's work adjustment or retention.
- (7) Ongoing support services needed to ensure the consumer's retention of the job.

(r) "Group services" means job coaching in a group supported employment placement at a job coach-to-consumer ratio of not less than one-to-three nor more than one-to-eight where services to a minimum of three consumers are funded by the regional center or the Department of Rehabilitation. For consumers receiving group services, ongoing support services shall be limited to job coaching and shall be provided at the worksite.

(s) "Individualized services" means job coaching and other supported employment services for regional center-funded consumers in a supported employment placement at a job coach-to-consumer ratio of one-to-one, and that decrease over time until stabilization is achieved. Individualized services may be provided on or off the jobsite.

SEC. 19. Section 5775 of the Welfare and Institutions Code is amended to read:

5775. (a) Notwithstanding any other provision of state law, the State Department of Mental Health shall implement managed mental health care for Medi-Cal beneficiaries through fee-for-service or capitated rate contracts with mental health plans, including individual counties, counties acting jointly, any qualified individual or organization, or a nongovernmental entity. 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 mental health services. The agreement may encompass all or any portion of the mental health services provided pursuant to this part. This agreement shall not relieve the individual counties of financial responsibility for providing these services. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall offer to contract with each county for the delivery of mental health services to that county's Medi-Cal beneficiary population prior to offering to contract with any other entity, upon terms at least as favorable as any offered to a noncounty contract provider. If a county elects not to contract with the department, does not renew its contract, or does not meet the minimum standards set by the department, the department may elect to contract with any other governmental or nongovernmental entity for the delivery of mental health services in that county and may administer the delivery of mental health services until a contract for a mental health plan is implemented. The county may not subsequently contract to provide mental health services under this part unless the department elects to contract with the county.

(d) If a county does not contract with the department to provide mental health services, the county shall transfer the responsibility for community Medi-Cal reimbursable mental health services and the anticipated county matching funds needed for community Medi-Cal mental health services in that county to the department. The amount of the anticipated county matching funds shall be determined by the department in consultation with the county, and shall be adjusted annually. The amount transferred shall be based on historical cost, adjusted for changes in the number of Medi-Cal beneficiaries and other relevant factors. The anticipated county matching funds shall be used by the department to contract with another entity for mental health services, and shall not be expended for any other purpose but the provision of those services and related administrative costs. The county shall continue to deliver non-Medi-Cal reimbursable mental health services in accordance with this division, and subject to subdivision (i) of Section 5777.

(e) Whenever the department determines that a mental health plan has failed to comply with this part or any regulations adopted pursuant to this part that implement this part, the department may impose sanctions, including, but not limited to, fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to prompt and ensure contract and performance compliance. If fines are imposed by the department, they may be withheld from the state matching funds provided to a mental health plan for Medi-Cal mental health services.

(f) Notwithstanding any other provision of law, emergency regulations adopted pursuant to Section 14680 to implement the second phase of mental health managed care as provided in this part shall remain in effect until permanent regulations are adopted, or June 30, 2006, whichever occurs first.

(g) The department shall convene at least two public hearings to clarify new federal regulations recently enacted by the federal Centers for Medicare and Medicaid Services that affect the state's second phase of mental health managed care and shall report to the Legislature on the results of these hearings through the 2005–06 budget deliberations.

(h) The department may adopt emergency regulations necessary to implement Part 438 (commencing with Section 438.1) of Subpart A of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations, in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of emergency regulations to implement this part, that are filed with the Office of Administrative Law within one year of the date on which the act that amended this subdivision in 2003 took effect, shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare, and shall remain in effect for no more than 180 days.

SEC. 20. Section 6606 of the Welfare and Institutions Code is amended to read:

6606. (a) A person who is committed under this article shall be provided with programming by the State Department of Mental Health which shall afford the person with treatment for his or her diagnosed mental disorder. Persons who decline treatment shall be offered the opportunity to participate in treatment on at least a monthly basis.

(b) Amenability to treatment is not required for a finding that any person is a person described in Section 6600, nor is it required for treatment of that person. Treatment does not mean that the treatment be successful or potentially successful, nor does it mean that the person must recognize his or her problem and willingly participate in the treatment program.

(c) The programming provided by the State Department of Mental Health in facilities shall be consistent with current institutional standards for the treatment of sex offenders, and shall be based on a structured treatment protocol developed by the State Department of Mental Health. The protocol shall describe the number and types of treatment components that are provided in the program, and shall specify how assessment data will be used to determine the course of treatment for each individual offender. The protocol shall also specify measures that will be used to assess treatment progress and changes with respect to the individual's risk of reoffense.

(d) Notwithstanding any other provision of law, except as to requirements relating to fire and life safety of persons with mental illness, and consistent with information and standards described in subdivision (c), the department is authorized to provide the programming using an outpatient/day treatment model, wherein treatment is provided by licensed professional clinicians in living units not licensed as health facility beds within a secure facility setting, on less than a 24-hour a day basis. The department shall take into consideration the unique characteristics, individual needs, and choices of persons committed under this article, including whether or not a person needs antipsychotic medication, whether or not a person has physical medical conditions, and whether or not a person chooses to participate in a specified course of offender treatment. The department shall ensure that policies and procedures are in place that

address changes in patient needs, as well as patient choices, and respond to treatment needs in a timely fashion. The department, in implementing this subdivision, shall be allowed by the State Department of Health Services to place health facility beds at Coalinga State Hospital in suspense for a period of up to six years. Coalinga State Hospital may remove all or any portion of its voluntarily suspended beds into active license status by request to the State Department of Health Services. The facility's request shall be granted unless the suspended beds fail to comply with current operational requirements for licensure.

(e) The department shall meet with each patient who has chosen not to participate in a specific course of offender treatment during monthly treatment planning conferences. At these conferences the department shall explain treatment options available to the patient, offer and re-offer treatment to the patient, seek to obtain the patient's cooperation in the recommended treatment options, and document these steps in the patient's health record. The fact that a patient has chosen not to participate in treatment in the past shall not establish that the patient continues to choose not to participate.

SEC. 20.1. Section 10506 is added to the Welfare and Institutions Code, to read:

10506. (a) Except as otherwise required by Sections 10614 and 14100.5, the State Department of Health Services (Genetically Handicapped Persons, CCS, CHDP, and the caseload programs in the Genetic Disease Branch), State Department of Alcohol and Drug Programs (Drug Medi-Cal Program), Managed Risk Medical Insurance Board, State Department of Developmental Services, State Department of Mental Health, Department of Rehabilitation, and Department of Child Support Services shall submit to the Department of Finance for its approval all assumptions underlying all estimates used to develop the departments' budgets by September 10 of each year, and those assumptions, as revised by, March 1 of the following year.

(b) The Department of Finance shall approve, modify, or deny the assumptions underlying all estimates within 15 working days of their submission. If the Department of Finance does not modify, deny, or otherwise indicate that the assumptions are open for consideration pending further information submitted by the department by that date, the assumptions as presented by the submitting department shall be deemed to be accepted by the Department of Finance as of that date.

(c) Each department or board described in subdivision (a) shall also submit an estimate of expenditures for each of the categorical aid programs in its budget to the Department of Finance by November 1 of each year and those estimates as revised by April 20 of the following year. Each estimate shall contain a concise statement identifying applicable estimate components, such as caseload, unit cost, implementation date, whether it is a new or continuing premise, and other assumptions necessary to support the estimate. The submittal shall include a projection of the fiscal impact of each of the approved assumptions related to a

regulatory, statutory, or policy change, a detailed explanation of any changes to the base estimate projections from the previous estimate, and a projection of the fiscal impact of that change to the base estimate.

(d) Each department or board shall identify those premises to which either of the following applies:

(1) Have been discontinued since the previous estimate was submitted. The department or board shall provide a chart that tracks the history of each discontinued premise in the prior year, the current year, and the budget year.

(2) Have been placed in the basic cost line of the estimate package.

(e) In the event that the methodological steps employed in arriving at the estimates in May differ from those used in November of the preceding year, the department or board shall submit a descriptive narrative of the revised methodology. In addition, the estimates shall include fiscal charts that track appropriations from the Budget Act to the current Governor's Budget and May Revision for all fund sources for the prior year, current year and budget year. This information shall be provided to the Department of Finance, the Joint Legislative Budget Committee, the Health and Human Services Policy Committees, and the fiscal committees, along with other materials included in the annual May revision of expenditure estimates.

(f) The estimates of average monthly caseloads, average monthly grants, total estimated expenditures, including administrative expenditures and savings or costs associated with all regulatory or statutory changes, as well as all supporting data provided by the department or developed independently by the Department of Finance, shall be made available to the Joint Legislative Budget Committee, the Health and Human Services Policy Committees, and the fiscal committees.

(g) On or after January 10, if the Department of Finance discovers a material error in the information provided pursuant to this section, the Department of Finance shall inform the consultants to the fiscal committees of the error in a timely manner.

(h) The departmental estimates, assumptions, and other supporting data prepared for purposes of this section shall be forwarded annually to the Joint Legislative Budget Committee, the Health and Human Services Policy Committees, and the fiscal committees of the Legislature, not later than January 10 and May 14 by the department or board if this information has not been released earlier by the Department of Finance.

(i) The requirements of this section do not apply to the State Department of Social Services estimate or the State Department of Health Services' Medi-Cal Program estimate, which are governed by Sections 10614 and 14100.5, respectively.

SEC. 20.2. Section 14001.11 is added to the Welfare and Institutions Code, to read:

14001.11. (a) The department shall implement the federal requirements described in Section 1396u-5 of Title 42 of the United States Code.

(b) In each of the several counties of the state, the eligibility and enrollment functions required under Section 1396u-5(a)(2) and (3) of Title 42 of the United States Code, which may include, but are not limited to, determining eligibility and offering enrollment for premium and cost sharing subsidies made available under and in accordance with Section 1395w-114 of Title 42 of the United States Code, shall be a county function and responsibility, subject to the direction, authority, and regulations of the department. The department shall request input from the counties as to the potential cost of implementing these provisions, and shall consider that input in developing the budget.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all county letters, provider bulletins, or similar instructions, with input from the counties. Thereafter, the department may adopt regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code.

(d) The department shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of federal financial participation under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other law and only when all necessary federal approvals have been obtained, this section, with the exception of the Phased-Down State Contribution, as described in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (c) of Section 1396u-5 of Title 42 of the United States Code, shall be implemented only to the extent federal financial participation is available.

SEC. 20.3. Section 14011.65 is added to the Welfare and Institutions Code, to read:

14011.65. (a) To the extent allowed under federal law and only if federal financial participation is available under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), the state shall administer the Medi-Cal to Healthy Families Accelerated Enrollment program, to provide any child who meets the criteria set forth in subdivision (b) with temporary health benefits for the period described in paragraph (2) of subdivision (b), as established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(b) (1) Any child who meets all of the following requirements, shall be eligible for temporary health benefits under this section:

(A) The child, or his or her parent or guardian, submits an application for the Medi-Cal program directly to the county.

(B) The child's income, as determined on the basis of the application described in subparagraph (A), is within the income limits established by the Healthy Families Program.

(C) The child is under 19 years of age at the time of the application.

(D) The county determines, on the basis of the application described in subparagraph (A), that the child is eligible for full-scope Medi-Cal with a share of cost.

(E) The child is not receiving Medi-Cal benefits at the time that the application is submitted.

(F) The child, or his or her parent or guardian, gives, or has given consent for the application to be shared with the Healthy Families Program for purposes of determining the child's Healthy Families Program eligibility.

(2) The period of accelerated eligibility provided for under this section begins on the first day of the month that the county finds that the child meets all of the criteria described in paragraph (1) and concludes on the last day of the month that the child either is fully enrolled in, or has been determined ineligible for, the Healthy Families Program.

(3) For any child who meets the requirements for temporary health benefits under this section, the county shall forward to the Healthy Families Program sufficient information from the child's application to determine eligibility for the Healthy Families Program. To the extent possible, submission of that information to the Healthy Families Program shall be accomplished using an electronic process developed for use in the Medi-Cal-to-Healthy Families Bridge Benefits Program. The department shall give the Healthy Families Program a daily electronic file of all children provided temporary health benefits pursuant to this section.

(4) The temporary health benefits provided under this section shall be identical to the benefits provided to children who receive full-scope Medi-Cal benefits without a share of cost and shall only be made available through a Medi-Cal provider.

(c) The department, in consultation with the Managed Risk Medical Insurance Board and representatives of the local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement this section.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department may adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The department shall seek approval of any amendments to the state plan necessary to implement this section, in accordance with Title XIX (42 U.S.C. Sec. 1396 et seq.) of the Social Security Act. Notwithstanding any other provision of law, only when all necessary federal approvals have been obtained shall this section be implemented.

(f) Under no circumstances shall this section be implemented unless the state has sought and obtained approval of any amendments to its state plan, as described in Section 12693.50 of the Insurance Code, necessary to implement this section and obtain funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) for the provision of benefits provided under this section. Notwithstanding any other provision of law,

and only when all necessary federal approvals have been obtained by the state, this section shall be implemented only to the extent federal financial participation under Title XXI of the Social Security Act(42 U.S.C. Sec. 1397aa et seq.) is available to fund benefits provided under this section.

(g) The department shall commence implementation of this section on the first day of the third month following the month in which federal approval of the state plan amendment or amendments described in subdivision (f), and subdivision (b) of Section 12693.50 of the Insurance Code is received, or on August 1, 2006, whichever is later.

SEC. 20.5. Section 14043.46 of the Welfare and Institutions Code is amended to read:

14043.46. (a) Notwithstanding any other provision of law, on the effective date of the act adding this section, the department may implement a one-year moratorium on the certification and enrollment into the Medi-Cal program of new adult day health care centers on a statewide basis or within a geographic area.

(b) The moratorium shall not apply to the following:

(1) Programs of All-Inclusive Care for the Elderly (PACE) established pursuant to Chapter 8.75 (commencing with Section 14590).

(2) An organization that currently holds a designation as a federally qualified health center as defined in Section 1396d(l)(2) of Title 42 of the United States Code.

(3) An organization that currently holds a designation as a federally qualified rural health clinic as defined in Section 1396d(l)(1) of Title 42 of the United States Code.

(4) An applicant with the physical location of the center in an unserved area, which is defined as a county having no licensed and certified adult day health care center within its geographic boundary.

(5) An applicant for licensure and certification that has been designated by a city and county, which, pursuant to a court order, is discharging persons currently residing in a city and county nursing facility to community housing, provided that all participants enrolled in the applicant's center are former residents of the city and county nursing facility.

(6) An applicant that is requesting expansion or relocation, or both, that has been Medi-Cal certified as an adult day health care center for at least four years, is expanding or relocating within the same county, and that meets one of the following population-based criteria:

(A) The county is ranked number one or two for having the highest ratio of persons over 65 years of age receiving Medi-Cal benefits.

(B) The county is ranked number one or two for having the highest ratio of persons over 85 years of age residing in the county.

(C) The county is ranked number one or two for having the greatest ratio of persons over 65 years of age living in poverty.

(7) An applicant for certification that is currently licensed and located in a county with a population that exceeds 9,000,000 and meets the following criteria:

(A) The applicant has identified a special population of regional center consumers whose individual program plan calls for the specialized health and social services that are uniquely provided within the adult day health care center, in order to prevent deterioration of the special population's health status.

(B) The referring regional center submits a letter to the Director of Health Services supporting the applicant for certification as an adult day health care provider for this special population.

(C) The applicant is currently providing services to the special population as a vendor of the referring regional center.

(D) The participants in the center are clients of the referring regional center and are not residing in a health facility licensed pursuant to subdivision (c), (d), (g), (h), or (k) of Section 1250 of the Health and Safety Code.

(c) The moratorium shall not prohibit the department from approving a change of ownership, relocation, or increase in capacity for an adult day health care center if the following conditions are met:

(1) For an application to change ownership, the adult day health care center meets all of the following conditions:

(A) Has been licensed and certified prior to the effective date of this section.

(B) Has a license in good standing.

(C) Has a record of substantial compliance with certification laws and regulations.

(D) Has met all requirements for the change application.

(2) For an application to relocate an existing facility, the relocation center must meet all of the conditions of paragraph (1) and both of the following conditions:

(A) Must be located in the same county as the existing licensed center.

(B) Must be licensed for the same capacity as the existing licensed center, unless the relocation center is located in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(3) For an application to increase the capacity of an existing facility, the center must meet all of the conditions of paragraph (1) and must be located in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(d) Following the first 180 days of the moratorium period, the department may make exceptions to the moratorium for new adult day health care centers that are located in underserved areas if the center's application was on file with the department on or before the effective date of the act adding this section. In order to apply for this exemption, an applicant or licensee must meet all of the following criteria:

(1) The applicant has control of a facility, either by ownership or lease agreement, that will house the adult day health care center, has provided to the department all necessary documents and fees, and has completed and submitted all required fingerprinting forms to the department.

(2) The physical location of the applicant's or licensee's adult day health care center is in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(e) During the period of the moratorium, a licensee or applicant that meets the criteria for an exemption as defined in subdivision (d) may submit a written request for an exemption to the director.

(f) If the director determines that a new adult day health care licensee or applicant meets the exemption criteria, the director may certify the licensee or applicant, once licensed, for participation in the Medi-Cal program.

(g) The director may extend this moratorium, if necessary, to coincide with the implementation date of the adult day health care waiver.

(h) The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in any other section.

SEC. 21. Section 14080 is added to the Welfare and Institutions Code, to read:

14080. (a) Notwithstanding any other provision of this chapter, reimbursement to providers for dental services provided to individuals 21 years of age or older at the time of services shall be limited to not more than one thousand eight hundred dollars (\$1,800) per beneficiary in any calendar year, commencing January 1, 2006. This limitation shall not apply to any of the following:

(1) Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(2) Services that are federally mandated under Part 440 (commencing with Section 440.1) of Title 42 of the Code of Federal Regulations, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

(3) Dentures.

(4) Maxillofacial and complex oral surgery.

(5) Maxillofacial services, including dental implants and implant-retained prostheses.

(6) Services provided in long-term care facilities.

(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 by means of all-county letters, provider bulletins, or similar instructions. No later than

January 1, 2008, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) The department shall pursue any state plan amendment or other federal approval necessary in order to effectuate this section. This section shall be implemented only to the extent that federal financial participation is available.

(d) This section shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends that date.

SEC. 22. Section 14085.6 of the Welfare and Institutions Code is amended to read:

14085.6. (a) Except as stated in subdivision (g), each hospital contracting to provide services under this article that meets the criteria contained in the state medicaid plan for disproportionate share hospital status shall be eligible to negotiate with the commission for distributions from the Emergency Services and Supplemental Payments Fund, which is hereby created. All distributions from the fund shall be pursuant to this section.

(b) (1) To the extent permitted by federal law, the department shall administer the fund in accordance with this section.

(2) The money in this fund shall be available for expenditure by the department for the purposes of this section, subject to approval through the regular budget process.

(c) The fund shall include all of the following:

(1) Subject to subdivision (l), all public funds transferred by public agencies to the department for deposit in the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal medicaid laws. These transfers shall constitute local government financial participation in Medi-Cal as permitted under Section 1902 (a)(2) of the Social Security Act (Title 42 U.S.C. Sec. 1396a (a)(2)) and other applicable federal medicaid laws.

(2) Subject to subdivision (l), all private donated funds transferred by private individuals or entities for deposit in the fund as permitted under applicable federal medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Interest that accrues on amounts in the fund.

(5) Moneys appropriated to the fund, or appropriated for poison control center grants and transferred to the fund, pursuant to the annual Budget Act.

(d) Amounts in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section.

(e) Distributions from the fund shall be supplemental to any and all other amounts that hospitals would have received under the contracting

program, and under the state medicaid plan, including contract rate increases and supplemental payments and payment adjustments under distribution programs relating to disproportionate share hospitals.

(f) Distributions from the fund shall not serve as the state's payment adjustment program under Section 1923 of the Social Security Act (42 U.S.C. Sec. 1396 r-4). To the extent permitted by federal law, and except as otherwise provided in this section, distributions from the fund shall not be subject to requirements contained in or related to Section 1923 of the Social Security Act (42 U.S.C. Sec. 1396 r-4). Distributions from the fund shall be supplemental contract payments and may be structured on any federally permissible basis, as negotiated between the commission and the hospital.

(g) In order to qualify for distributions from the fund, a hospital shall meet all of the following criteria:

(1) Be a contracting hospital under this article.

(2) Satisfy the state medicaid plan criteria referred to in subdivision (a).

(3) Be one of the following:

(A) A licensed provider of basic emergency services as described in Sections 70411 and following of Title 22 of the California Code of Regulations.

(B) A licensed provider of comprehensive emergency medical services as defined in Sections 70451 and following of Title 22 of the California Code of Regulations.

(C) A children's hospital as defined in Section 14087.21 that satisfies subparagraph (A) or (B) or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(D) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(E) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(4) Be able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(h) (1) The department shall seek federal financial participation for expenditures made from the fund to the full extent permitted by federal law.

(2) The department shall promptly seek any necessary federal approvals regarding this section.

(i) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in following fiscal years.

(j) For purposes of this section, “fund” means the Emergency Services and Supplemental Payments Fund.

(k) (1) Any public agency transferring amounts to the fund, as specified in paragraph (1) of subdivision (c), may for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public funds or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(2) Notwithstanding paragraph (1), a public agency may transfer to the fund only those moneys that have a source that will qualify for federal financial participation under the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) or other applicable federal medicaid laws.

(l) Public funds transferred pursuant to paragraph (1) of subdivision (c), and private donated funds transferred pursuant to paragraph (2) of subdivision (c), shall be deposited into the fund, and expended pursuant to this section. The director may accept only those funds that are certified by the transferring entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) and may return any funds transferred in error.

(m) The department may adopt emergency regulations, if necessary, for the purposes of this section.

(n) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup that federal disallowance from the hospital in any manner authorized by law or contract.

SEC. 22.1. Section 14087.48 is added to the Welfare and Institutions Code, to read:

14087.48. (a) For purposes of this section “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089), or pursuant to Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8.

(b) Before a Medi-Cal managed care plan commences operations based upon an action of the director that expands the geographic area of Medi-Cal managed care, the department shall perform an evaluation to determine the readiness of any affected Medi-Cal managed care plan to

commence operations. The evaluation shall include, at a minimum, all of the following:

(1) The extent to which the Medi-Cal managed care plan demonstrates the ability to provide reliable service utilization and cost data, including, but not limited to, quarterly financial reports, audited annual reports, utilization reports of medical services, and encounter data.

(2) The extent to which the Medi-Cal managed care plan has an adequate provider network, including, but not limited to, the location, office hours, and language capabilities of primary care physicians, specialists, pharmacies, and hospitals, that the types of specialists in the provider network are based on the population makeup and particular geographic needs, and that whether requirements will be met for availability of services and travel distance standards, as set forth in Sections 53852 and 53885, respectively, of Title 22 of the California Code of Regulations.

(3) The extent to which the Medi-Cal managed care plan has developed procedures for the monitoring and improvement of quality of care, including, but not limited to, procedures for retrospective reviews which include patterns of practice reviews and drug prescribing practice reviews, utilization management mechanisms to detect both under- and over-utilization of health care services, and procedures that specify timeframes for medical authorization.

(4) The extent to which the Medi-Cal managed care plan has demonstrated the ability to meet accessibility standards in accordance with Section 1300.67.2 of Title 28 of the California Code of Regulations, including, but not limited to, procedures for appointments, waiting times, telephone procedures, after hours calls, urgent care, and arrangement for the provision of unusual specialty services.

(5) The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees.

(6) The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollment and disenrollments.

(7) The extent to which the Medi-Cal managed care plan's Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood.

(8) The extent to which the Medi-Cal managed care plan's primary care and facility sites have been reviewed and evaluated by the department.

SEC. 22.2. Section 14087.54 of the Welfare and Institutions Code is amended to read:

14087.54. (a) Any county or counties may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care in the county or counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) (1) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to “county” shall mean a commission established pursuant to this section.

(2) The commission operating in Santa Cruz and Monterey Counties pursuant to this section may also enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program, if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs. The commission shall not use any payments or reserves from the Medi-Cal program for this purpose.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission’s activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or

issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at such time as the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

SEC. 22.5. Section 14093.06 is added to the Welfare and Institutions Code, to read:

14093.06. (a) When a managed care contractor authorized to provide California Children's Services (CCS) covered services pursuant to subdivision (a) of Section 14094.3 expands to other counties, the contractor shall comply with CCS program standards including, but not limited to, referral of newborns to the appropriate neonatal intensive care level, referral of children requiring pediatric intensive care to CCS-approved pediatric intensive care units, and referral of children with CCS eligible conditions to CCS-approved inpatient facilities and special care centers in accordance with subdivision (c) of Section 14093.05.

(b) The managed care contractor shall comply with CCS program medical eligibility regulations. Questions regarding interpretation of state CCS medical eligibility regulations, or disagreements between the county CCS program, and the managed care contractor regarding interpretation of those regulations, shall be resolved by the local CCS program, in consultation with the state CCS program. The resolution determined by the CCS program shall be communicated in writing to the managed care contractor.

(c) In following the treatment plan approved by the CCS program, the managed care contractor shall ensure the timely referral of children with special health care needs to CCS-paneled providers who are board-certified in both pediatrics and in the appropriate pediatric subspecialty.

(d) The managed care contractor shall report expenditures and savings separately for CCS covered services and CCS eligible children, in accordance with paragraph (1) of subdivision (d) of Section 14093.05.

(e) All children who are enrolled with a managed care contractor who are seeking CCS program benefits shall retain all rights to CCS program appeals and fair hearings of denials of medical eligibility or of service authorizations. Information regarding the number, nature, and disposition of appeals and fair hearings shall be part of an annual report to the Legislature on managed care contractor compliance with CCS standards, regulations, and procedures. This report shall be made available to the public.

(f) The state, in consultation with stakeholder groups, shall develop unique pediatric plan performance standards and measurements, including, but not limited to, the health outcomes of children with special health care needs.

SEC. 23. Section 14105.23 is added to the Welfare and Institutions Code, to read:

14105.23. (a) Reimbursement for portable X-ray transportation services, as defined in paragraph (2) of subdivision (b) of Section 51531 of Title 22 of the California Code of Regulations, shall not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar services.

(b) Notwithstanding subdivision (a) of Section 14105 and the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may establish the rates of reimbursement for the services described in subdivision (a) by means of a provider bulletin or manual, or similar instructions.

SEC. 24. Section 14105.24 is added to the Welfare and Institutions Code, to read:

14105.24. (a) Clinics and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County that participated in the California Section 1115 Medicaid Demonstration Project for Los Angeles County (No. 11-W-00076/9) and received 100 percent cost-based reimbursement pursuant to the Special Terms and Conditions of that waiver shall continue to be reimbursed under a cost-based methodology on and after July 1, 2005.

(b) Reimbursement to clinics and hospitals described in subdivision (a) shall be at 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications:

(1) The Medicare reimbursement methodology as specified at Sections 405.2460 to 405.2470, inclusive, of Title 42 of the Code of Federal Regulations, together with applicable definitions in Subpart X of Part 405 of Title 42 of the Code of Federal Regulations to the extent those definitions are applied by the department in connection with payments to federally qualified health centers in California.

(2) Cost reimbursement principles outlined in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations. In the event of a conflict between the provisions of Part 405 and Part 413, the provisions of Part 405 shall govern.

(3) “Cost Principles for State, Local, and Indian Tribe Governments” (OMB Circular A-87).

(4) “Rural Health and FQHC Manual” (CMS Publication 27).

(5) Subdivision (e) of Section 14087.325 and any implementing regulations.

(c) The methodology for reimbursement adopted by the state to comply with Section 1396a(aa) of Title 42 of the United States Code shall not be applicable to clinics and hospitals that are paid pursuant to this section.

(d) This section shall be implemented on the effective date established by the federal Centers for Medicare and Medicaid Services for an amendment to the California Medicaid State Plan that approves the cost-based reimbursement methodology for the clinics and hospitals described in subdivision (b).

(e) Notwithstanding subdivision (a) of Section 14105, and the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer the cost-based rates of reimbursement described in this section by means of provider bulletins or manuals, or similar instructions.

SEC. 25. Section 14105.48 of the Welfare and Institutions Code is amended to read:

14105.48. (a) The department shall establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment as defined in Section 51160 of Title 22 of the California Code of Regulations and the list shall be published in provider manuals. The list shall specify utilization controls to be applied to each type of durable medical equipment.

(b) Reimbursement for durable medical equipment, except wheelchairs, wheelchair accessories, and speech-generating devices and related accessories, shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, or (2) an amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(c) Reimbursement for wheelchairs, wheelchair accessories, and speech-generating devices and related accessories shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, or (2) an amount that does not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(d) Reimbursement for all durable medical equipment billed to the Medi-Cal program utilizing codes with no specified maximum allowable rate shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, or (2) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department, or (3) the actual acquisition cost plus a markup to be established by the department, or (4) the manufacturer's suggested retail purchase price reduced by a percentage discount not to exceed 20 percent, or (5) a price established through targeted product-specific cost containment provisions developed with providers.

(e) Reimbursement for all durable medical equipment supplies and accessories billed to the Medi-Cal program shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, or (2) the acquisition cost plus a 23 percent markup.

(f) Any regulation in Division 3 of Title 22 of the California Code of Regulations that contains provisions for reimbursement rates for durable medical equipment shall be amended or repealed effective for dates of service on or after the date of the act adding this section.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, actions under this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

(h) The department shall consult with interested parties and appropriate stakeholders in implementing this section with respect to all of the following:

- (1) Notifying the provider representatives of the proposed change.
- (2) Scheduling at least one meeting to discuss the change.
- (3) Allowing for written input regarding the change.
- (4) Providing advance notice on the implementation and effective date of the change.

(i) The department may require providers of durable medical equipment to appeal Medicare denials for dually eligible beneficiaries as a condition of Medi-Cal payment.

SEC. 25.5. Section 14105.7 of the Welfare and Institutions Code is amended to read:

14105.7. (a) In order to fairly reimburse pharmacies for the furnishing of prescription drugs to Medi-Cal beneficiaries, the director shall update

allowable drug product prices within seven days of receiving notice of a drug product price change. Notice to the director shall include, but not be limited to, publication of the price change in the supplier's catalog or supplement or in nationally distributed drug price reference guides.

(b) No regulation reducing allowable drug product cost reimbursement or removing a drug from the Medi-Cal list of contract drugs shall be operative until at least 30 days after eligible pharmacies have been mailed a notice of the reimbursement limitation by the department or the fiscal intermediary.

(c) The director shall limit the rate of payment for the professional fee portion of prescription services rendered under this chapter pursuant to Section 4064 of the Business and Professions Code or Section 11201 of the Health and Safety Code and the professional fee portion of prescription services rendered as a refill immediately subsequent to such prescription to ensure that the total professional fee paid for the two services does not exceed the professional fee paid for the same prescription refill when provided as a routine service.

SEC. 26. Section 14115.8 of the Welfare and Institutions Code is amended to read:

14115.8. (a) (1) The department shall amend the Medicaid state plan with respect to the billing option for services by local education agencies, to ensure that schools shall be reimbursed for all eligible services that they provide that are not precluded by federal requirements.

(2) The department shall examine methodologies for increasing school participation in the Medi-Cal billing option for local education agencies so that schools can meet the health care needs of their students.

(3) The department, to the extent possible shall simplify claiming processes for local education agency billing.

(4) The department shall eliminate and modify state plan and regulatory requirements that exceed federal requirements when they are unnecessary.

(b) If a rate study for the LEA Medi-Cal billing option is completed pursuant to Section 52 of Chapter 171 of the Statutes of 2001, the department, in consultation with the entities named in subdivision (c), shall implement the recommendations from the study, to the extent feasible and appropriate.

(c) In order to assist the department in formulating the state plan amendments required by subdivisions (a) and (b), the department shall regularly consult with the State Department of Education, representatives of urban, rural, large and small school districts, and county offices of education, the local education consortium, local education agencies, and the local education agency technical assistance project. It is the intent of the Legislature that the department also consult with staff from Region IX of the federal Centers for Medicare and Medicaid Services, experts from the fields of both health and education, and state legislative staff.

(d) Notwithstanding any other provision of law, or any other contrary state requirement, the department shall take whatever action is necessary to ensure that, to the extent there is capacity in its certified match, a local

education agency shall be reimbursed retroactively for the maximum period allowed by the federal government for any department change that results in an increase in reimbursement to local education agency providers.

(e) The department may undertake all necessary activities to recoup matching funds from the federal government for reimbursable services that have already been provided in the state's public schools. The department shall prepare and take whatever action is necessary to implement all regulations, policies, state plan amendments, and other requirements necessary to achieve this purpose.

(f) The department shall file an annual report with the Legislature that shall include at least all of the following:

(1) A copy of the annual comparison required by subdivision (i).

(2) A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available.

(3) A summary of department activities and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states.

(4) A listing of all school-based services, activities, and providers approved for reimbursement by the federal Centers for Medicare and Medicaid Services in other state plans that are not yet approved for reimbursement in California's state plan and the service unit rates approved for reimbursement.

(5) The official recommendations made to the department by the entities named in subdivision (c) and the action taken by the department regarding each recommendation.

(6) A one-year timetable for state plan amendments and other actions necessary to obtain reimbursement for those items listed in paragraph (4).

(7) Identify any barriers to local education agency reimbursement, including those specified by the entities named in subdivision (c), that are not imposed by federal requirements, and describe the actions that have been, and will be, taken to eliminate them.

(g) (1) These activities shall be funded and staffed by proportionately reducing federal Medicaid payments allocable to local educational agencies for the provision of benefits funded by the federal Medicaid program under the billing option for services by local educational agencies specified in this section. Moneys collected as a result of the reduction in federal Medicaid payments allocable to local educational agencies shall be deposited into the Local Education Agency Medi-Cal Recovery Account, which is hereby established in the Special Deposit Fund established pursuant to Section 16370 of the Government Code. These funds shall be used only to support the department to meet all the requirements of this section. As of January 1, 2010, unless the Legislature enacts a new statute or extends the date beyond January 1, 2010, all funds in the Local Education Agency Medi-Cal Recovery Account shall be returned

proportionally to all local educational agencies whose federal Medicaid funds were used to create this account. The annual amount funded shall not exceed one million five hundred thousand dollars (\$1,500,000).

(2) Commencing with the 2003-04 fiscal year, funding received pursuant to paragraph (1) shall derive only from federal Medicaid funds that exceed the baseline amount of local educational agency Medicaid billing option revenues for the 2000-01 fiscal year.

(h) (1) The department may enter into a sole source contract to comply with the requirements of this section.

(2) The level of additional staff to comply with the requirements of this section, including, but not limited to, staff for which the department has contracted for pursuant to paragraph (1), shall be limited to that level that can be funded with revenues derived pursuant to subdivision (g).

(i) The activities of the department shall include all of the following:

(1) An annual comparison of the school-based Medicaid systems in comparable states.

(2) Efforts to improve communications with the federal government, the State Department of Education, and local education agencies.

(3) The development and updating of written guidelines to local education agencies regarding best practices to avoid audit exceptions, as needed.

(4) The establishment and maintenance of a local education agency friendly interactive Web site.

(j) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 27. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients

in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(l) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

- (1) Level of care and cost of care evaluations.
- (2) Expenses, directly attributable to home care activities, for materials.
- (3) Physician fees for home visits.
- (4) Expenses directly attributable to home care activities for shelter and modification to shelter.
- (5) Expenses directly attributable to additional costs of special diets, including tube feeding.
- (6) Medically related personal services.
- (7) Home nursing education.
- (8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for

the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and

the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) 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, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost-effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those

objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

- (i) Psychosocial and medical aspects of contraception.
- (ii) Sexuality.
- (iii) Fertility.
- (iv) Pregnancy.
- (v) Parenthood.
- (vi) Infertility.
- (vii) Reproductive health care.
- (viii) Preconception and nutrition counseling.
- (ix) Prevention and treatment of sexually transmitted infection.
- (x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.
- (xi) Possible contraceptive consequences and followup.
- (xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a

complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(ab) Purchase of prescribed enteral formulae is covered, subject to the Medi-Cal list of enteral formulae and utilization controls.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 27.1. Section 14133.23 is added to the Welfare and Institutions Code, to read:

14133.23. (a) To the extent that federal financial participation is not available, the provision of drug benefits under this chapter to full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a Medicare Advantage-Prescription Drug plan (MA-PD plan) under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.), is eliminated, except as otherwise provided under this section.

(b) (1) Notwithstanding any other provision of law, only drug benefits for which federal financial participation is available shall be provided under this chapter to a full-benefit dual eligible beneficiary, except as otherwise provided under subdivision (c).

(2) As a benefit under this chapter, the department, subject to the approval of the Department of Finance and only to the extent that federal financial participation is available, may elect to provide a drug or drugs in a class of drugs not covered under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a MA-PD plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) to full-benefit dual eligible beneficiaries.

(3) As a benefit under this chapter, and only to the extent that federal financial participation is available, the department shall provide a drug or drugs to full-benefit dual eligible beneficiaries who are otherwise eligible to receive the drug or drugs due to their entitlement under Title 42 United States Code, Chapter 7, Title XVIII, Part A or their enrollment under Title 42 United States Code, Chapter 7, Title XVIII, Part B.

(4) Except as provided under paragraph (3) and subdivision (c), nothing in this section shall be interpreted to require the department to provide any drug or drugs not covered under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a MA-PD plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) if federal financial participation is not available.

(c) (1) The department shall review the drug formularies of prescription drug plans under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or MA-PD plans under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) available to full-benefit dual eligible beneficiaries.

(2) The department shall develop a process that would allow the department to provide to a full-benefit dual eligible beneficiary, on an emergency basis only, coverage for a drug or drugs not included on the full-benefit dual eligible beneficiary's prescription drug plan's formulary or by prior authorization under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or MA-PD plans under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) for which federal financial participation is not available.

(3) Only to the extent that the Legislature made a specific appropriation to fund the provision of emergency drug benefits for which federal financial participation is not available to full-benefit dual eligible beneficiaries, the department shall provide, through the process described in paragraph (2), these emergency drug benefits to a full-benefit dual eligible beneficiary only when all of the following conditions are met:

(A) The drug is not available to the full-benefit dual eligible beneficiary under his or her plan's drug formulary or by prior authorization.

(B) The pharmacist provides or dispenses the drug as an emergency service.

(C) The quantity of the drug provided or dispensed is no greater than a 60-day supply.

(D) The pharmacist has not previously provided or dispensed nor has knowledge that another pharmacist has provided or dispensed the same drug for that full-benefit dual eligible beneficiary on or after January 1, 2006.

(E) The date of service is from January 1, 2006 through December 31, 2006, inclusive.

(4) The department may impose a pre- or post- service prepayment or postpayment review or audit, to review the medical necessity of emergency services provided to full-benefit dual eligible beneficiaries.

(d) The department shall seek approval of any amendments to the state plan necessary to implement this section as required by Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret or make specific this section by means of all county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) For the purposes of this section, a "full-benefit dual eligible beneficiary" means an individual who meets both of the following criteria:

(1) The beneficiary is eligible or would be eligible for coverage for the month for covered Part D drugs under a prescription drug plan under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a MA-PD plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.).

(2) Notwithstanding any other provision of this section, the beneficiary is determined eligible for full scope services, including drug benefits, for which federal financial participation is available.

(g) Subdivisions (a) and (b) and paragraph (3) of subdivision (c) shall become operative on January 1, 2006.

SEC. 28. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office. The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the California Work Opportunity and Responsibility to Kids (CalWORKs), Food Stamp, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed so as to limit the administrative or budgetary responsibilities of the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. Nothing in this section shall be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.

(B) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

(2) (A) The department shall establish best-practice guidelines for expedited enrollment of newborns into the Medi-Cal program, preferably with the goal of enrolling newborns within 10 days after the county is informed of the birth. The department, in consultation with counties and other stakeholders, shall work to develop a process for expediting enrollment for all newborns, including those born to mothers receiving CalWORKs assistance.

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(C) Notwithstanding the rulemaking procedures of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters or similar instructions, without further regulatory action.

(3) Perform timely annual redeterminations, as follows:

(A) Ninety percent of the annual redetermination forms shall be mailed to the recipient by the anniversary date.

(B) Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner.

(C) Ninety percent of those annual redeterminations where the redetermination form has not been returned to the county by the recipient shall be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

(D) When a child is determined by the county to change from no share of cost to a share of cost and the child meets the eligibility criteria for the Healthy Families Program established under Section 12693.98 of the Insurance Code, the child shall be placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program, and these cases shall be processed as follows:

(i) Ninety percent of the families of these children shall be sent a notice informing them of the Healthy Families Program within five working days from the determination of a share of cost.

(ii) Ninety percent of all annual redetermination forms for these children shall be sent to the Healthy Families Program within five working days from the determination of a share of cost if the parent has given consent to send this information to the Healthy Families Program.

(iii) Ninety percent of the families of these children placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program who have not consented to sending the child's annual redetermination form to the Healthy Families Program shall be sent a request, within five working days of the determination of a share of cost, to consent to send the information to the Healthy Families Program.

(E) Subparagraph (D) shall not be implemented until 60 days after the Medi-Cal and Joint Medi-Cal and Healthy Families applications and the Medi-Cal redetermination forms are revised to allow the parent of a child to consent to forward the child's information to the Healthy Families Program.

(d) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(e) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(f) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county 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 county shall take to improve its performance on the standard of standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(g) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

(h) The department shall develop procedures, in collaboration with the counties and stakeholders, for developing instructions for the performance standards established under subparagraph (D) of paragraph (3) of subdivision (c), no later than September 1, 2005.

(i) No later than September 1, 2005, the department shall issue a revised annual redetermination form to allow a parent to indicate parental consent to forward the annual redetermination form to the Healthy Families Program if the child is determined to have a share of cost.

(j) The department, in coordination with the Managed Risk Medical Insurance Board, shall streamline the method of providing the Healthy Families Program with information necessary to determine Healthy Families eligibility for a child who is receiving services under the Medi-Cal-to-Healthy Families Bridge Benefits Program.

SEC. 29. Section 14495.10 of the Welfare and Institutions Code is amended to read:

14495.10. (a) The department shall establish a pilot program to provide continuous skilled nursing care as a benefit of the Medi-Cal program, when those services are provided in accordance with an approved federal waiver meeting the requirements of subdivision (b). “Continuous skilled nursing care” means medically necessary care provided by, or under the supervision of, a registered nurse within his or her scope of practice, seven days a week, 24 hours per day, in a health facility participating in the pilot program. This care shall include a minimum of eight hours per day provided by or under the direct supervision of a registered nurse. Each health facility providing continuous skilled nursing care in the pilot program shall have a minimum of one registered nurse or one licensed vocational nurse awake and in the facility at all times.

(b) The department shall submit to the federal Centers for Medicare and Medicaid Services, no later than April 1, 2000, a federal waiver request developed in consultation with the State Department of Developmental Services and the Association of Regional Center Agencies, pursuant to Section 1915(b) of the federal Social Security Act to provide continuous skilled nursing care services under the pilot program.

(c) (1) The pilot program shall be conducted to explore more flexible models of health facility licensure to provide continuous skilled nursing care to developmentally disabled individuals in the least restrictive health facility setting, and to evaluate the effect of the pilot program on the health, safety, and quality of life of individuals, and the cost-effectiveness of this care. The evaluation shall include a review of the pilot program by an independent agency.

(2) Participation in the pilot program shall include 10 health facilities provided that the facilities meet all eligibility requirements. The facilities shall be approved by the department, in consultation with the State Department of Developmental Services and the appropriate regional center agencies, and shall meet the requirements of subdivision (e). Priority shall be given to facilities with four to six beds, to the extent those facilities meet all other eligibility requirements.

(d) Under the pilot program established in this section, a developmentally disabled individual is eligible to receive continuous skilled nursing care if all of the following conditions are met:

(1) The developmentally disabled individual meets the criteria as specified in the federal waiver.

(2) The developmentally disabled individual resides in a health facility that meets the provider participation criteria as specified in the federal waiver.

(3) The continuous skilled nursing care services are provided in accordance with the federal waiver.

(4) The continuous skilled nursing care services provided to the developmentally disabled individual do not result in costs that exceed the fiscal limit established in the federal waiver.

(e) A health facility seeking to participate in the pilot program shall provide care for developmentally disabled individuals who require the availability of continuous skilled nursing care, in accordance with the terms of the pilot program. During participation in the pilot program, the health facility shall comply with all the terms and conditions of the federal waiver described in subdivision (b), and shall not be subject to licensure or inspection under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Upon termination of the pilot program and verification of compliance with Section 1265 of the Health and Safety Code, the department shall immediately reinstate the participating health facility's previous license for the balance of time remaining on the license when the health facility began participation in the pilot program.

(f) The department shall implement this pilot program only to the extent it can demonstrate fiscal neutrality, as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals to implement the pilot program and receives federal financial participation from the federal Centers for Medicare and Medicaid Services.

(g) In implementing this article, the department may enter into contracts for the provision of essential administration and other services. Contracts entered into under this section may be on a noncompetitive bid basis and shall be exempt from the requirements of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(h) This section shall remain in effect only until January 1, 2008, and as of that date is repealed, unless a later enacted statute that becomes effective on or before January 1, 2008, deletes or extends that date.

SEC. 30. Section 16809 of the Welfare and Institutions Code, as amended by Section 27 of Chapter 228 of the Statutes of 2004, is amended to read:

16809. (a) (1) The board of supervisors of a county that contracted with the department pursuant to Section 16709 during the 1990-91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program. The County Medical Services Program shall have responsibilities for specified health services to county residents certified eligible for those services by the county.

(2) If the County Medical Services Program Governing Board contracts with the department to administer the County Medical Services Program, that contract shall include, but need not be limited to, all of the following:

(A) Provisions for the payment to participating counties for making eligibility determinations based on the formula used by the County Medical Services Program for the 1993-94 fiscal year.

(B) Provisions for payment of expenses of the County Medical Services Program Governing Board.

(C) Provisions relating to the flow of funds from counties' vehicle license fees, sales taxes, and participation fees and the procedures to be followed if a county does not pay those funds to the program.

(D) Those provisions, as applicable, contained in the 1993-94 fiscal year contract with counties under the County Medical Services Program.

(3) The contract between the department and the County Medical Services Program Governing Board shall require that the County Medical Services Program Governing Board shall reimburse three million five hundred thousand dollars (\$3,500,000) for the state costs of providing administrative support to the County Medical Services Program. The department may decline to implement decisions made by the governing board that would require a greater level of administrative support than that for the 1993-94 fiscal year. The department may implement decisions upon compensation by the governing board to cover that increased level of support.

(4) The contract between the department and the County Medical Services Program Governing Board may include provisions for the administration of a pharmacy benefit program and, pursuant to these provisions, the department may negotiate, on behalf of the County Medical Services Program, rebates from manufacturers that agree to participate. The governing board shall reimburse the department for staff costs associated with this paragraph.

(5) The department shall administer the County Medical Services Program pursuant to the provisions of the 1993-94 fiscal year contract with the counties and regulations relating to the administration of the program until the County Medical Services Program Governing Board executes a contract for the administration of the County Medical Services Program and adopts regulations for that purpose.

(6) The department shall not be liable for any costs related to decisions of the County Medical Services Program Governing Board that are in excess of those set forth in the contract between the department and the County Medical Services Program Governing Board.

(b) Each county intending to participate in the County Medical Services Program pursuant to this section shall submit to the Governing Board of the County Medical Services Program a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year in which the county will participate in the County Medical Services Program.

(c) A county participating in the County Medical Services Program pursuant to this section shall not be relieved of its indigent health care obligation under Section 17000.

(d) (1) The County Medical Services Program Account is established in the County Health Services Fund. The County Medical Services Program Account is continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years. The following amounts may be deposited in the account:

(A) Any interest earned upon money deposited in the account.

(B) Moneys provided by participating counties or appropriated by the Legislature to the account.

(C) Moneys loaned pursuant to subdivision (q).

(2) The methods and procedures used to deposit funds into the account shall be consistent with the methods used by the program during the 1993-94 fiscal year.

(e) Moneys in the program account shall be used by the department, pursuant to its contract with the County Medical Services Program Governing Board, to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j) and to pay for the expense of the governing board as set forth in the contract between the board and the department. In addition, moneys in this account may be used to reimburse the department for state costs pursuant to paragraph (3) of subdivision (a).

(f) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, at the end of the 1982-83 fiscal year and every six months thereafter, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, County Medical Services Program Governing Board expenses, or for expenditures to augment the program's rates, benefits, or eligibility criteria pursuant to subdivision (j).

(g) A separate County Medical Services Program Reserve Account is established in the County Health Services Fund. Six months after the end of each fiscal year, any projected savings in the program account shall be transferred to the reserve account, with final settlement occurring no more than 12 months later. Moneys in this account shall be utilized when expenditures for health services made pursuant to subdivision (j) for a fiscal year exceed the amount of funds available in the program account for that fiscal year. When funds in the reserve account are estimated to exceed 10 percent of the budget for health services for all counties electing

to participate in the County Medical Services Program under this section for the fiscal year, the additional funds shall be available for expenditure to augment the rates, benefits, or eligibility criteria pursuant to subdivision (j) or for reducing the participation fees as determined by the County Medical Services Program Governing Board pursuant to subdivision (i). Nothing in this section shall preclude the CMSP Governing Board from establishing other reserves.

(h) Moneys in the program account and the reserve account, except for moneys provided by the state in excess of the amount required to fund the state risk specified in subdivision (j), and any funds loaned pursuant to subdivision (q) shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited in the program account, notwithstanding Section 16705.7 of the Government Code.

(i) (1) Counties shall pay participation fees as established by the County Medical Services Program Governing Board and their jurisdictional risk amount in a method that is consistent with that established in the 1993-94 fiscal year.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the CMSP Governing Board.

(3) Payments made pursuant to this subdivision shall be deposited in the program account.

(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) For the 1991-92 fiscal year and all preceding fiscal years, the state shall be at risk for any costs in excess of the amounts deposited in the reserve fund.

(B) (i) Beginning in the 1992-93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 1999-2000, 2000-01, 2001-02, 2002-03, 2003-04, 2004-05, and 2005-06 fiscal years. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus the additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 1999-2000, 2000-01, 2001-02, 2002-03, 2003-04, 2004-05, and 2005-06 fiscal years. In the 1994-95 fiscal year, the amount of the state risk shall be twenty million two hundred thirty-seven thousand

four hundred sixty dollars (\$20,237,460) per fiscal year, in addition to the cost of administrative support pursuant to paragraph (3) of subdivision (a).

(ii) For the 1999-2000, 2000-01, 2001-02, 2002-03, 2003-04, 2004-05, and 2005-06 fiscal years, the state shall not be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus any additional cost increases for the 1999-2000, 2000-01, 2001-02, 2002-03, 2003-04, 2004-05, and 2005-06 fiscal years.

(C) The CMSP Governing Board, after consultation with the department, shall establish uniform eligibility criteria and benefits for the County Medical Services Program.

(2) For the 1991-92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction	Amount
Alpine.....	\$ 13,150
Amador.....	620,264
Butte.....	5,950,593
Calaveras.....	913,959
Colusa.....	799,988
Del Norte.....	781,358
El Dorado.....	3,535,288
Glenn.....	787,933
Humboldt.....	6,883,182
Imperial.....	6,394,422
Inyo.....	1,100,257
Kings.....	2,832,833
Lassen.....	687,113
Madera.....	2,882,147
Marin.....	7,725,909
Mariposa.....	435,062
Modoc.....	469,034
Mono.....	369,309
Napa.....	3,062,967
Nevada.....	1,860,793
Plumas.....	905,192
San Benito.....	1,086,011
Shasta.....	5,361,013
Sierra.....	135,888
Siskiyou.....	1,372,034
Solano.....	6,871,127
Sonoma.....	13,183,359
Sutter.....	2,996,118
Tehama.....	1,912,299
Trinity.....	611,497

Jurisdiction	Amount
Tuolumne.....	1,455,320
Yuba.....	2,395,580

(3) Beginning in the 1991-92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the 1990-91 fiscal year shall be the amount specified in paragraph (A) plus the amount determined pursuant to paragraph (B), minus the amount specified by the County Medical Services Program Governing Board as participation fees.

(A)

Jurisdiction	Amount
Lake.....	\$1,022,963
Mendocino.....	1,654,999
Merced.....	2,033,729
Placer.....	1,338,330
San Luis Obispo.....	2,000,491
Santa Cruz.....	3,037,783
Yolo.....	1,475,620

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the CMSP Governing Board before a county is permitted to participate in the County Medical Services Program.

(4) For the 1994-95 and 1995-96 fiscal years, the specific amounts and method of apportioning risk to each participating county may be adjusted by the CMSP Governing Board.

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. Contracts of the department pursuant to this section shall have no force or effect unless they are approved by the Department of Finance.

(l) The state shall not incur any liability except as specified in this section.

(m) Third-party recoveries for services provided under this section pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 may be pursued.

(n) Under the program provided for in this section, the department may reimburse hospitals for inpatient services at the rates negotiated for the Medi-Cal program by the California Medical Assistance Commission, pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3, if the California Medical Assistance Commission determines that reimbursement to the hospital at the contracted rate will not have a detrimental fiscal impact on either the Medi-Cal program or the program provided for in this section. In negotiating and renegotiating contracts with

hospitals, the commission may seek terms which allow reimbursement for patients receiving services under this section at contracted Medi-Cal rates.

(o) Any hospital which has a contract with the state for inpatient services under the Medi-Cal program and which has been approved by the commission to be reimbursed for patients receiving services under this section shall not deny services to these patients.

(p) Participating counties may conduct an independent program review to identify ways through which program savings may be generated. The counties and the department may collectively pursue identified options for the realization of program savings.

(q) The Department of Finance may authorize a loan of up to thirty million dollars (\$30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(r) Regulations adopted by the department pursuant to this section shall remain operative and shall be used to operate the County Medical Services Program until a contract with the County Medical Services Program Governing Board is executed and regulations, as appropriate, are adopted by the County Medical Services Program Governing Board. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, those regulations adopted under the County Medical Services Program shall become inoperative until January 1, 1998, except those regulations that the department, in consultation with the County Medical Services Program Governing Board, determines are needed to continue to administer the County Medical Services Program. The department shall notify the Office of Administrative Law as to those regulations the department will continue to use in the implementation of the County Medical Services Program.

(s) Moneys appropriated from the General Fund to meet the state risk as set forth in subparagraph (B) of paragraph (1) of subdivision (j) shall not be available for those counties electing to disenroll from the County Medical Services Program.

(t) This section shall remain in effect only until January 1, 2008, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2008, deletes or extends that date.

SEC. 31. Section 16809 of the Welfare and Institutions Code, as amended by Section 28 of Chapter 228 of the Statutes of 2004, is amended to read:

16809. (a) The board of supervisors of a county that contracted with the department pursuant to Section 16709 during the 1990-91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, may enter into a contract with the department and the department may enter into a contract with that county under which the department agrees to administer the program responsibilities for specified health services to county residents certified eligible for those services by the county.

(b) Each county intending to contract with the department pursuant to this section shall submit to the department a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year for which the agreement will be in effect in accordance with procedures established by the department.

(c) A county contracting with the department pursuant to this section shall not be relieved of its indigent health care obligation under Section 17000.

(d) The department shall establish the County Medical Services Program Account in the County Health Services Fund. The County Medical Services Program Account is continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years. The following amounts may be deposited in the account:

(1) Any interest earned upon money deposited in the account.

(2) Moneys provided by participating counties or appropriated by the Legislature to the account.

(3) Moneys loaned pursuant to subdivision (q).

(e) Moneys in the program account shall be used by the department to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j).

(f) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, at the end of the 1982-83 fiscal year and every six months thereafter, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, or for expenditures to augment the program's rates, benefits, or eligibility criteria pursuant to subdivision (j).

(g) The department shall establish a separate County Medical Services Program Reserve Account in the County Health Services Fund. Six months after the end of each fiscal year, any projected savings in the program account shall be transferred to the reserve account, with final settlement occurring no more than 12 months later. Moneys in this account shall be utilized when expenditures for health services made pursuant to subdivision (j) for a fiscal year exceed the amount of funds available in the program account for that fiscal year. When funds in the reserve account are estimated to exceed 10 percent of the budget for health services for all counties electing to contract with the department under this section for the fiscal year, the additional funds shall be available for expenditure to augment the rates, benefits, or eligibility criteria pursuant to subdivision (j) or for reducing the participation fees required by Section 16809.3.

(h) Moneys in the program account and the reserve account, except for moneys provided by the state in excess of the amount required to fund the state risk specified in subdivision (j), and any funds loaned pursuant to subdivision (q), shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited in the program account, notwithstanding Section 16705.7 of the Government Code.

(i) (1) Counties shall pay by the 15th of each month the agreed-upon contract amount. In the event a county does not make the agreed-upon monthly payment, the department may terminate the county’s participation in the program.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the Small County Advisory Committee.

(3) Payments made pursuant to this subdivision shall be deposited in the program account.

(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) For the 1991-92 fiscal year and all preceding fiscal years, the state shall be at risk for any costs in excess of the amounts deposited in the reserve fund.

(B) Beginning in the 1992-93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 1999-2000, 2000-01, 2001-02, 2002-03, 2003-04, 2004-05, and 2005-06 fiscal years. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600 according to the table specified in paragraph (2) to the County Medical Services Program, plus additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year.

(C) As a condition of the state assuming this risk, the department may require uniform eligibility criteria and benefits to be provided which shall be mutually established by participating counties in conjunction with the department. The County Medical Services Program Governing Board may revise these eligibility criteria and benefits or alter rates of payment in order to assure that expenditures do not exceed the funds available in the program account.

(2) For the 1991-92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction

Amount

Alpine.....	\$ 13,150
Amador.....	620,264
Butte.....	5,950,593
Calaveras.....	913,959
Colusa.....	799,988
Del Norte.....	781,358
El Dorado.....	3,535,288
Glenn.....	787,933
Humboldt.....	6,883,182
Imperial.....	6,394,422
Inyo.....	1,100,257
Kings.....	2,832,833
Lassen.....	687,113
Madera.....	2,882,147
Marin.....	7,725,909
Mariposa.....	435,062
Modoc.....	469,034
Mono.....	369,309
Napa.....	3,062,967
Nevada.....	1,860,793
Plumas.....	905,192
San Benito.....	1,086,011
Shasta.....	5,361,013
Sierra.....	135,888
Siskiyou.....	1,372,034
Solano.....	6,871,127
Sonoma.....	13,183,359
Sutter.....	2,996,118
Tehama.....	1,912,299
Trinity.....	611,497
Tuolumne.....	1,455,320
Yuba.....	2,395,580

(3) Beginning in the 1991-92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the 1990-91 fiscal year shall be the amount specified in paragraph (A) plus the amount determined pursuant to paragraph (B), minus the amount specified in Section 16809.3.

(A)

Jurisdiction	Amount
Lake.....	1,022,963
Mendocino.....	1,654,999
Merced.....	2,033,729
Placer.....	1,338,330
San Luis Obispo.....	2,000,491
Santa Cruz.....	3,037,783

Yolo..... 1,475,620

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the department. This amount shall be subject to the approval of both the Department of Finance and the Small County Advisory Committee before a county is permitted to contract back with the department.

(4) For the 1992-93 fiscal year and fiscal years thereafter, the amounts of the jurisdictional risk limitations shall be adjusted according to the provisions of paragraph (2).

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. Contracts shall have no force and effect unless approved by the Department of Finance.

(l) The state shall not incur any liability except as specified in this section.

(m) The department may pursue third-party recoveries for services provided under this section pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3.

(n) Under the program provided for in this section, the department shall reimburse hospitals for inpatient services at the rates negotiated for the Medi-Cal program by the California Medical Assistance Commission, pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3, if the California Medical Assistance Commission determines that reimbursement to the hospital at the contracted rate will not have a detrimental fiscal impact on either the Medi-Cal program or the program provided for in this section. In negotiating and renegotiating contracts with hospitals, the commission may seek terms which allow reimbursement for patients receiving services under this section at contracted Medi-Cal rates.

(o) Any hospital which has a contract with the state for inpatient services under the Medi-Cal program and which has been approved by the commission to be reimbursed for patients receiving services under this section shall not deny services to these patients.

(p) Participating counties may conduct an independent program review to identify ways through which program savings may be generated. The counties and the department shall collectively pursue identified options for the realization of program savings.

(q) The Department of Finance may authorize a loan of up to thirty million dollars (\$30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(r) This section shall become operative January 1, 2008.

SEC. 32. The Managed Risk Medical Insurance Board may adopt regulations to implement Sections 3, 4, and 5 to 11, inclusive, of this act. The adoption, amendment, repeal, or readoption of a regulation authorized

by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the Managed Risk Medical Insurance Board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

SEC. 33. (a) At the time of the release of the January 10 budget plan and the May Revision, the Director of Mental Health shall submit to the Legislature information regarding the projected expenditure of Proposition 63 funding for each state department, and for each major program category specified in the measure, for local assistance. This shall include actual past-year expenditures, estimated current-year expenditures, estimated current-year expenditures, and projected budget-year expenditures of local assistance funding.

(b) During each fiscal year, the Director of Mental Health shall submit to the fiscal committees of the Legislature, 30 days in advance, written notice of the intention to expend Proposition 63 local assistance funding in excess of the amounts presented in its May Revision projection for that fiscal year. The written notice shall include information regarding the amount of the additional spending and its purpose.

SEC. 34. The State Department of Health Services shall provide the fiscal and policy committees of the Legislature with quarterly updates, commencing January 1, 2006, regarding core activities to improve the Medi-Cal Managed Care Program and to expand to the 13 new counties, as directed by the Budget Act of 2005. The quarterly updates shall include key milestones and objectives of progress regarding changes to the existing program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and applicable key functions related to the Medi-Cal Managed Care expansion effort.

SEC. 35. (a) The State Department of Health Services shall coordinate its federal bioterrorism activities, as applicable, with the California Office of Binational Border Health, as the single point of coordination on border health activities.

(b) These activities shall, at a minimum, include all of the following:

- (1) Surveillance for the spread of infectious disease.
- (2) Monitoring for environmental health safety issues related to food safety and air and water quality.
- (3) Responding to any potential bioterrorism threat.

SEC. 36. (a) The State Department of Developmental Services shall include explicit language in its contracts with regional center agencies to require each regional center to use funds allocated in the Budget Act of 2005 for complying with Medicaid Home and Community-Based Services

Waiver requirements solely for the specific purposes budgeted for the 2005-06 fiscal year and each fiscal year thereafter.

(b) The State Department of Developmental Services may take any disciplinary action necessary in the event a regional center expends these allocated funds for any other purpose than for complying with the requirements of the Home and Community-Based Waiver.

(c) By October 31, 2005, each regional center shall report to the State Department of Developmental Services on the Regional Center's average service coordinator-to-consumer caseload ratio for all consumers enrolled in the Home and Community-Based Services Waiver. This report shall be in addition to the caseload reporting required pursuant to subdivision (e) of Section 4640.6 of the Welfare and Institutions Code.

SEC. 37. On an annual basis, the State Department of Health Services and the California Medical Assistance Commission shall provide fiscal information to the Joint Legislative Audit Committee and the Joint Legislative Budget Committee on the funds provided to the contract hospitals participating in the Medi-Cal program, and the health plans participating in the Medi-Cal Managed Care Program, for implementation of nurse-to-patient ratios.

SEC. 38. By July 1, 2009, the State Department of Health Services shall provide the Legislature with data comparing the University of California, Davis (UC Davis), baseline study of nurse staffing levels released in May 2002 to staffing of registered nurse and other licensed nurse staffing subsequent to the full implementation of the licensed nurse-to-patient ratios on January 1, 2008, in accordance with the UC Davis study. The 2008 study shall be a stratified probability sample of California acute care hospitals at the nursing unit level.

SEC. 39. Notwithstanding Section 12739 of the Insurance Code, on a one-time basis for the 2005-06 budget year, upon order of the Director of Finance, the controller shall reduce the amounts to be deposited in the Major Risk Medical Insurance Fund as follows:

(a) A three million one hundred seven thousand dollar (\$3,107,000) reduction from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund.

(b) A five million eight hundred ninety-three thousand dollar (\$5,893,000) reduction from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund.

(c) A one million dollar (\$1,000,000) reduction from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund.

SEC. 39.1. (a) Of the funds appropriated in Item 4260-111-0001 of Section 2 of the Budget Act of 2005 from the Cigarette and Tobacco Products Surtax Fund, twenty-four million eight hundred three thousand dollars (\$24,803,000) shall be allocated in accordance with subdivision (b) for the 2005-06 fiscal year from the following accounts:

(1) Twenty million two hundred twenty-seven thousand dollars (\$20,227,000) from the Hospital Services Account.

(2) Four million five hundred seventy-six thousand dollars (\$4,576,000) from the Physician Services Account.

(b) The funds specified in subdivision (a) shall be allocated proportionately as follows:

(1) Twenty-two million three hundred twenty-four thousand dollars (\$22,324,000) shall be administered and allocated for distribution through the California Healthcare for Indigents Program (CHIP), Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(2) Two million four hundred seventy-nine thousand dollars (\$2,479,000) shall be administered and allocated through the rural health services program, Chapter 4 (commencing with Section 16930) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(c) (1) Funds allocated pursuant to this section from the Physician Services Account and the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for the reimbursement of physicians for losses incurred in providing uncompensated emergency services in general acute care hospitals providing basic, comprehensive, or standby emergency services, as defined in Section 16953 of the Welfare and Institutions Code. Funds shall be transferred to the Physician Services Account in the county Emergency Medical Services Fund established pursuant to Sections 16951 and 16952 of the Welfare and Institutions Code, and shall be paid only to physicians who directly provide emergency medical services to patients, based on claims submitted or a subsequent reconciliation of claims. Payments shall be made as provided in Sections 16951 to 16959, inclusive, of the Welfare and Institutions Code, and payments shall be made on an equitable basis, without preference to any particular physician or group of physicians.

(2) If a county has an EMS Fund Advisory Committee that includes both emergency physicians and emergency department on-call back-up panel physicians, and if the committee unanimously approves, the administrator of the EMS Fund may create a special fee schedule and claims submission criteria for reimbursement for services rendered to uninsured trauma patients, provided that no more than 15 percent of the tobacco tax revenues allocated to the County's EMS Fund is distributed through this special fee schedule, that all physicians who render trauma services are entitled to submit claims for reimbursement under this special fee schedule, and that no physician's claim may be reimbursed at greater than 50 percent of losses under this special fee schedule.

SEC. 40. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 41. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of

Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement the Budget Act of 2005 at the earliest possible time, it is necessary that this act take effect immediately.

O