Assembly Bill No. 1807

CHAPTER 74

An act to amend Section 1300 of the Business and Professions Code, to amend Sections 1214, 1214.1, 1214.5, 1337.6, 1338.5, 1403, 1575.9, 1729, 1730, 1736.2, 1743.17, 1743.19, 1750, 1794.06, 100922, 103526, 103526.5, 107080, 111615, 111625, 115065, 115080, 117995, 118210, and 124977 of, to add Sections 1266.5, 1266.7, 1266.9, 1266.10, 1266.12, 1760.5, 101315.2, and 117971 to, to repeal Sections 1337.7, 1403.1, 1729.1, 1736.3, and 100445 of, and to repeal and add Section 1266 of, the Health and Safety Code, to amend Sections 12693.70, 12696.05, and 12699 of, and to add Section 12695.03 to, the Insurance Code, to amend Section 830.3 of the Penal Code, and to amend Sections 4107, 4640.6, 4643, 4648.4, 4681.3, 4681.5, 4691.6, 4694, 4781.5, 4860, 5675.2, 14011.2, 14043.46, 14105.33, 14105.48, 14105.49, 14154, 14572, 14592, and 16809 of, and to add Sections 4690.5, 4691.8, 14007.2, 14067.3, 14068, and 14133.07 to, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor July 12, 2006. Filed with Secretary of State July 12, 2006.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1807, Committee on Budget. Health.

Existing law provides for the licensure and certification by the State Department of Health Services of persons providing various health services, including hemodialysis technicians. Existing law provides that the certification and renewal fees for hemodialysis technicians shall be $50.

This bill would delete the provision setting the certification and renewal fees for hemodialysis technicians.

Existing law establishes provisions specifying the responsibilities of the State Department of Health Services in the implementation of various programs in the administration of public health. Existing law provides for the licensure and regulation of clinics and health facilities, as defined, and certain health care providers.

This bill would provide that, unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation, the Licensing and Certification Division of the department shall, no later than the beginning of the 2009–10 fiscal year, be supported entirely by federal funds and special funds.

Existing law establishes specified licensing fees for various clinics, health facilities, including hospitals, skilled nursing facilities, congregate living facilities, intermediate care facilities, and correctional treatment centers, and health care providers, including referral agencies, adult day health care agencies, home health agencies, private duty nursing agencies, hospices, pediatric day health and respite care facilities, and home dialysis agencies, and freestanding cardiac catheterization laboratories.

Existing law requires each new and renewal application for a license for specified health facilities to be accompanied by an annual fee, as specified.

This bill would specify the licensing and certification program fees applicable to various clinics, health care providers, and health facilities, including the above clinics, health care providers, and health facilities, for the 2006–07 fiscal year. The bill would require the department, commencing February 1, 2007, and every February 1 thereafter, to publish a list of estimated fees applicable to those providers and facilities, and to adjust those fees as specified. It would require the department to prepare and publish specified reports relating to the licensing and certification of those providers and facilities. The bill would provide for certain late payment penalties when any of those entities continues to operate beyond its license expiration date.

This bill would establish, within the Special Deposit Fund, the State Department of Health Services Licensing and Certification Program Account, and would specify that revenues collected for the licensing of specified health care providers shall be deposited in the account, for allocation, upon appropriation by the Legislature, to support the department's licensing and certification program. It would appropriate $3,204,370 from the General Fund to the department for a loan for use in the support of the department's licensing and certification program to be repaid from the proceeds of fees collected for the licensing and certification of the above health providers and facilities.

This bill would require the department, commencing January 1, 2007, to give priority in conducting initial licensing surveys to each intermediate care facility/developmentally disabled, intermediate care facility/developmentally disabled habilitative, and intermediate care facility/developmentally disabled nursing.

Existing law establishes requirements, administered by the department, for certification as a certified nurse assistant, and imposes specified fees in connection with that certification.

This bill would repeal those fee provisions.

Existing law requires that a criminal record clearance shall be conducted for all nurse assistants by the submission of fingerprint cards to the department for processing at the Department of Justice, and requires completion of the criminal record clearance prior to issuance or renewal of a certificate. Existing law provides that the fee to cover the processing costs of the Department of Justice shall not exceed a specified amount.

This bill would require each health facility that operates and is used as a clinical skills site for certification training, and each health facility, prior to

hiring a nurse assistant applicant certified in another state or country, to arrange for and pay the cost of the fingerprint live-scan service and the Department of Justice processing costs for each applicant. The bill would prohibit health facilities from passing these costs through to nurse assistant applicants unless allowed by federal law.

Existing law regulates the licensing of home health agencies and private duty nursing agencies, and certification of certified home health aides. Existing law requires an application for renewal of a home health agency license or a private duty nursing agency license to be filed not less than 10 days prior to its expiration date.

This bill would require, instead, that the application for renewal be filed not less than 30 days prior to its expiration date.

Existing law imposes various fees in connection with home health aide certification.

This bill would repeal those fee provisions.

The bill would provide that, of certain funds appropriated in the Budget Act of 2006 for local jurisdictions to prepare for public health emergencies, a specified amount shall be provided to each local jurisdiction first, with the remaining amount allocated based on population.

Existing law, commencing July 1, 2007, prohibits local registrars and county recorders from issuing an informational certified copy of a birth or death certificate unless the source of the issuance is the statewide database prepared by the State Registrar and specifies that the security paper used for an informational certified copy of those records shall also contain a statement in perforated type that states it is informational and not a valid document to establish identity.

This bill would apply the limitation to the issuance of those records on July 1, 2007, but only after the statewide database becomes operational and the information is entered into the database. This bill would also extend the date on which the requirement for the statement would be applied to January 1, 2009.

Existing law prohibits any person from manufacturing any drug or device in the state unless he or she has a valid license from the state and provides that the license is valid for one year from the date of issue, unless it is revoked.

This bill would extend the period of the license to 2 years, unless it is revoked.

Existing law provides for the regulation and licensing of persons possessing radioactive materials and persons generally licensed for the use of devices and equipment utilizing radioactive materials.

This bill would require the State Department of Health Services to establish fees for followup inspections related to the failure to correct violations of those regulations.

Existing law provides for the regulation of large quantity medical waste generators and medical waste treatment facilities, including the registration of, and the issuance of permits to, those medical waste generators and

treatment facilities. Existing law specifies the annual fees that the department is required to collect for this permit registration process.

This bill would require the department, in addition, to recover its actual costs for services related to large quantity medical waste generator followup inspections and enforcement activities necessary to ensure compliance with these provisions.

The bill would authorize permits for medical waste treatment facilities and large quantity medical waste generators to be issued biennially.

Existing law specifies the annual fee for an offsite medical waste treatment facility.

This bill would increase the amount of that fee, as specified.

Existing law requires the State Department of Health Services to charge a fee for newborn screening and followup services, to be paid to the Genetic Disease Testing Fund.

This bill would provide that the expenditure of funds from the Genetic Disease Testing Fund for the expansion of the Genetic Disease Branch Screening Information System to include cystic fibrosis and biotinidase may be implemented through the amendment of the Genetic Disease Branch Screening Information System contracts, and shall not be subject to specified provisions of law governing public contracts and information systems technology. It would provide that this exemption shall also apply to the maintenance and operation of the Genetic Disease Branch Screening Information System once the expansion is implemented.

Existing law provides for various health programs under which qualified low-income persons are provided health care services, including the Healthy Families Program, which is administered by the Managed Risk Medical Insurance Board. Existing law continuously appropriates funds to the board from the Healthy Families Fund for the program.

Under existing law, the Healthy Families Program includes a purchasing pool providing health coverage for children in families without affordable employer based dependent coverage. Existing law provides that if an applicant for the purchasing pool does not have a family contribution sponsor, the applicant shall pay the first month's family contribution and shall agree to remain in the program for 6 months.

This bill would make ineligible for the program, commencing July 1, 2007, an infant who is enrolled in employer-sponsored health insurance or who is eligible for the full scope of Medi-Cal benefits at no share of cost. This bill would also eliminate the first month contribution requirement and apply the requirement to agree to stay in the program for 6 months to any program applicant. By increasing eligibility of a subscriber under the Healthy Families Program, this bill would increase subscriber contributions and would result in an appropriation.

Existing law, the Access to Infants and Mothers Program, is administered by the Managed Risk Medical Insurance Board. Existing law sets forth eligibility requirements for the program and permits the board to determine subscriber amount schedules.

Existing law established the Perinatal Insurance Fund in the State Treasury as a continuously appropriated fund to be used for the purposes of the Access for Infants and Mothers Program and the Healthy Families Fund, which is continuously appropriated to the board for the purposes of funding the Healthy Families Program.

This bill would authorize the board to assess an additional subscriber contribution, for 2 months, for subscribers enrolled on or after July 1, 2007, with respect to an AIM-linked infant in the Healthy Families Program, and would specify that the board shall determine the portion of the subscriber contribution that shall be transferred from the Perinatal Insurance Fund to the Healthy Families Fund for payment of the Healthy Families Program premium for an AIM-linked infant, as defined. By transferring funds to a continuously appropriated fund, the bill would result in an appropriation.

Existing law provides that certain specified persons are peace officers, and includes all investigators of the State Department of Developmental Services.

This bill would instead provide that the Chief, Deputy Chief, supervising investigators, and investigators of the State Office of Protective Services of the State Department of Developmental Services are within the scope of that definition, provided that the primary duty of each of those peace officers shall be the enforcement of the law relating to the duties of his or her department or office.

Existing law provides that the State Department of Mental Health shall house no more than 1,336 patients at Patton State Hospital, with the exception that until one year after the activation of the Coalinga Secure Treatment Facility, up to 1,670 patients may be housed at the hospital.

This bill would instead, authorize the housing of up to 1,530 patients at the hospital in those circumstances until September 2009.

Existing law requires each regional center for persons with developmental disabilities to provide service coordinator caseload data to the State Department of Mental Health, as specified.

This bill would provide that, for purposes of calculating caseload ratios for consumers enrolled in the Home- and Community-based Services Waiver program, vacancies shall not be included in the calculations.

Existing law provides for the assessment of certain individuals for whom benefits are provided by regional centers for persons with developmental disabilities. Existing law specifies that if assessment is needed, prior to July 1, 2006, the assessment shall be performed within 120 days following initial intake, and requires that assessments after that date shall be performed within 60 days following intake.

This bill would extend the 120-day assessment requirement until July 1, 2007.

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 limits the

rate of payment a regional center may pay a provider for specified services to a rate that is in effect on or after June 30, 2004, with certain exceptions.

This bill would require that, as of July 1, 2006, rates for specified services shall be increased by 3%, subject to funds appropriated for this purpose in the Budget Act. The bill would, for the 2006–07 fiscal year, except with respect to those services, limit the rate of payment a regional center may pay a provider to a rate that is in effect on or after July 1, 2006, except as provided.

The bill would increase the rate schedule in effect on June 30, 2006, for community care facilities serving persons with developmental disabilities by 3% on July 1, 2006, subject to funds specifically appropriated for this increase in the Budget Act of 2006.

Existing law provides that, during the 2005−06 fiscal year, no regional center may approve any service level for a residential service provider if the approval would result in an increase to be paid to the provider that is greater than the rate in effect on or after June 30, 2005.

This bill would make that limitation applicable with respect to the 2006–07 fiscal year, and would base the limitation on the rate in effect on or after July 1, 2006.

Existing law prohibits during the 2005−06 fiscal year, the State Department of Developmental Services from establishing any permanent payment rate for a community-based day program or in-home respite care agency that has a temporary payment rate in effect on June 30, 2005.

This bill would apply that prohibition to the 2006–07 fiscal year. The bill would provide that, commencing July 1, 2006, the community-based day program, work activity program, and in-home respite service agency rate schedules authorized by the department and in operation June 30, 2006, shall be increased by 3%, subject to funds specifically appropriated for this increase in the Budget Act of 2006.

The bill would, commencing July 1, 2006, increase the rate for family member-provided respite services authorized by the department and in operation June 30, 2006, by 3%, subject to funds specifically appropriated for this increase in the Budget Act of 2006.

The bill would permit the department, to the extent funds are appropriated in the annual Budget Act for this purpose, to provide a rate increase for the purpose of enhancing wages for direct care staff in day programs and in work activity programs, and in similar programs, for individuals who are developmentally disabled that meet any of specified criteria.

This bill would, commencing July 1, 2006, require certain regional center vendors who are serving individuals enrolled under a specified Home- and Community-based Services Waiver program for persons with developmental disabilities to ensure that billing information provided to regional centers identifies prescribed information necessary to support billing under the waiver. It would require regional centers to ensure that their contractual and other billing and payment arrangements with

providers require the provision of any information necessary to support billing under the waiver.

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, for the 2005–06 fiscal year, a regional center may not expend any purchase of service funds for the startup of any new program unless certain criteria are met, except as specified.

This bill would apply these provisions to the 2006–07 fiscal year. The bill would revise the criteria for expending purchase of service funds for the startup of a new program, and would add additional criteria. The bill would create an exception from these provisions for grants to current providers to engage in new or expanded employment activities that result in greater integration, conversion from sheltered to supported work environments, self-employment, and increased consumer participation in the federal Ticket to Work program.

This bill would increase the hourly rate, as prescribed, for supported employment services provided to persons with developmental disabilities receiving individualized and group services.

Existing law provides that any new or renewal licensure application fees for psychiatric health facilities shall be collected by the State Department of Mental Health.

This bill would create in the State Treasury the Licensing and Certification Fund, Mental Health, from which moneys, upon appropriation by the Legislature, shall be expended by the State Department of Mental Health to fund administrative and other activities in support of the Licensing and Certification Program administered by the department.

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

Existing state and federal law requires every applicant or beneficiary under the Medi-Cal program or, in the case of a child, the child's caretaker relative or legal guardian on his or her behalf, to declare, under penalty of perjury, that he or she is, or is not, a citizen or national of the United States. Existing federal law requires, as of July 1, 2006, that every person who declares to be a citizen or national of the United States present satisfactory documentary evidence of citizenship or nationality, as specified.

This bill would require an individual who declares to be a citizen or national of the United States to present satisfactory documentary evidence of citizenship or nationality in compliance with the above provisions of federal law. The bill would provide that no services shall be available under the Medi-Cal program for an individual who fails to comply with these requirements, except as specified. The bill would provide that, to the

extent federal financial participation is available, if an individual cooperates in the effort to obtain and present the documentation required by these provisions, the individual shall be given as much time as is allowed by federal law and policy to present that documentation. The bill would require counties to assist individuals to obtain the required documentation, and would impose certain other duties on counties with respect to these documentation requirements. By expanding the duties of county agencies in administering eligibility requirements under the Medi-Cal program, the bill would impose a state-mandated local program.

Existing law provides that an immigrant who does not meet specified requirements regarding his or her immigration status, and who is otherwise eligible for Medi-Cal services, shall only be eligible for certain emergency medical services, long-term care services, and pregnancy-related services, except as specified.

This bill would provide that any individual who is otherwise eligible for Medi-Cal services, but who does not meet the documentation requirements described above, shall be eligible only for the scope of services made available to immigrants under the above provisions.

Existing law, the Adult Day Health Care Act, provides for the licensure and regulation of adult day health care centers.

Existing law provides for the certification and enrollment of adult day health care centers as Medi-Cal providers. Existing law allows the State Department of Health Services to 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, and allows the Director of Health Services to extend this moratorium to coincide with a specified waiver. Existing law creates certain exemptions from this moratorium, including an exemption for an applicant for licensure and certification that has been designated by a city and county which, pursuant to a court order, is discharging certain persons from a nursing facility to community housing.

This bill, commencing May 1, 2006, would revise this exemption and would include additional conditions, as specified.

Existing law allows the State Department of Health Services to enter into contracts with drug manufacturers for drugs from each major therapeutic category, and requires it to maintain a list of those drugs for which contracts have been executed. Existing law requires these contracts to provide for an equalization payment amount, as defined.

This bill would require that utilization data used to determine an equalization payment amount include data from all programs that qualify for federal drug rebates pursuant to specified provisions of the federal Social Security Act, or that otherwise qualify for federal funds under that act pursuant to the Medicaid state plan or waivers.

Existing law requires the department to establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment, as defined. Existing law requires that reimbursement for all durable medical equipment billed to the Medi-Cal program using codes

with no specified maximum allowable rate be the lesser of certain amounts, including the manufacturer's suggested retail price, reduced by a percentage discount not to exceed 20%.

This bill would base this amount, instead, on the manufacturer's suggested retail purchase price on June 1, 2006, and documented by a printed catalog or a hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 20%, or not to exceed 15% for wheelchairs and wheelchair accessories if the provider employs or contracts with a qualified rehabilitation professional, as defined. The bill would require, commencing January 1, 2007, that reimbursement for oxygen delivery systems and oxygen contents utilize certain national codes, and be the lesser of specified amounts. The bill would require the department, within a specified period, to review the utilization of those services and equipment resulting from these changes, and to notify the Joint Legislative Budget Committee if it finds an increase in inappropriate use of those services or equipment.

Existing law requires the department to establish a list of hearing aids and hearing aid accessories and determine the maximum allowable product cost for each hearing aid product provided under the Medi-Cal program, and requires that the list be published in provider bulletins.

This bill would revise provisions governing maximum reimbursement rates for hearing aids and hearing aid accessories, and would authorize the department to implement those provisions by provider manual or bulletin.

Existing law allows specified utilization controls, including prior authorization, to be applied to covered Medi-Cal services that are subject to utilization controls. Under existing law, outpatient podiatric services are a covered benefit, subject to utilization controls.

This bill would provide, commencing October 1, 2006, that prior authorization for podiatric services provided on an outpatient or inpatient basis shall not be required when specified conditions are met.

Existing law requires the State Department of Health Services to establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under the Medi-Cal program will be effectively controlled within the amounts annually appropriated for that administration. Existing law requires the plan to establish standards and performance criteria.

This bill would state the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in these provisions.

Existing law requires the State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board, to develop and conduct a community outreach and education campaign to help families learn about, and apply for, the Medi-Cal program and the Healthy Families Program.

This bill would allow the State Department of Health Services to maintain an allocation program for the management and funding of county

outreach and enrollment plans to enroll and retain eligible children in the Medi-Cal program and the Healthy Families Program. The bill would require that a specified amount of the funds appropriated for these purposes be set aside for counties meeting certain criteria. It would require a county to submit an allocation plan to obtain these funds.

Existing law allows the Director of Health Services to contract with any qualified individual, organization, or entity to provide Medi-Cal managed care services.

This bill would require that, in conducting outreach activities for the enrollment of special needs populations into the Medi-Cal managed care program, the State Department of Health Services and its contractors, as deemed applicable by the department, work with state, local, and regional organizations with the ability to target low-income seniors and individuals with disabilities in the communities where they live.

Existing law establishes the California Program of All-Inclusive Care for the Elderly (PACE), to promote the development of community-based, risk-based capitated long-term care programs. Existing law allows the Director of Health Services to contract with up to 10 demonstration projects to develop risk-based long-term care pilot programs.

This bill would require the State Department of Health Services to establish the monthly capitation fee paid to each PACE organization at no less than a specified amount, subject to federal financial participation.

Existing law prohibits Medi-Cal reimbursement from being made for a service rendered by an adult day health care provider that does not have a license as an adult day health care center or that does not have currently effective Medi-Cal certification.

This bill would require that, notwithstanding this prohibition, Medi-Cal certification be granted as of the date of licensure with respect to, and reimbursement be made for, a service rendered on or after that date if the provider meets specified requirements.

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, may, by adopting a resolution to that effect, elect to participate in the County Medical Services Program for state administration of health care services to eligible persons in the county. Existing law revises, for the 2005–06 fiscal year, state and county financial responsibilities for certain increases in the County Medical Services Program.

This bill would further extend that revision to include the 2006–07 fiscal year.

Existing law requires the State Department of Mental Health to provide specified information to the appropriate fiscal and policy committees of the Legislature regarding the operation of the Metropolitan State Hospital.

This bill would require, in addition, commencing in September 2006 and every 3 months thereafter, that the department provide, pursuant to a

consent decree, specified information produced within the previous 6 months by a court monitor, and certain other documents, to those legislative committees, until the state is in compliance with the consent decree.

This bill would refer an audit request to the Bureau of State Audits to conduct an audit during the 2007–08 fiscal year of the clinical laboratory oversight programs of the State Department of Health Services to assess the department's practices and procedures for enforcing state laws and regulations regarding the licensing, certification, and registration of clinical laboratories. It would provide that this audit request shall be considered by the Bureau of State Audits within its overall audit requests, and would require that the results of any audit conducted pursuant to these provisions be reported to the chairs of specified committees of the Legislature.

This bill would allocate the amount of $24,803,000 in funds appropriated in the Budget Act of 2006 from the Cigarette and Tobacco Products Surtax Fund, and would specify the amount from which of each account in the fund the appropriated funds shall be allocated. The bill would specify the proportional allocation of those funds for distribution by the California Healthcare for Indigents Program, the rural health services program, and would limit the uses for which those funds may be applied.

Existing federal law provides for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, under which children covered by Medicaid receive specified health and mental health services.

This bill would require the State Department of Mental Health to revise its method for auditing entities that provide specialty mental health services under the EPSDT program, and its method for extrapolating data obtained from those audits, as specified.

Existing law requires that specified educational and related services be provided to a child with a disability pursuant to an individualized education plan. Existing law provides that the State Department of Mental Health, or any community mental health service designated by that department, is responsible for the provision of mental health services to such a child, if required in the individualized education program for the child.

This bill would require, commencing with the Budget Act of 2006, that funds provided to county mental health department pursuant to specified appropriations in the annual Budget Act be timely, and that the funds be used exclusively to provide state-mandated services pursuant to the above provisions. The bill would provide that the State Department of Education shall be responsible for the timely distribution to county offices of education of specified funds appropriated in the Budget Act of 2006 for mental health services for students with individualized education plans pursuant to the above provisions, and would require that the timing of distributions meet certain requirements. The bill would require that, commencing in the 2007–08 fiscal year, as a condition of receiving specified funds appropriated in the Budget Act of 2006, a county mental

health department and the appropriate county office of education, or a single entity designated by the county office of education, enter into a memorandum of understanding. The bill would require the State Department of Mental Health to develop a template of the memorandum of understanding, containing specified elements, by October 1, 2006, for use by county mental health departments and county offices of education, and would require the memoranda of understanding to be adopted by county mental health departments and county offices of education by May 1, 2007. The bill would require the State Department of Mental Health and the State Department of Education, by May 1, 2007, to collaboratively develop claiming instructions for the appropriations for county mental health programs under these provisions.

The bill would require the State Department of Health Services to provide to the fiscal committees of the Legislature, by no later than March 15, 2007, specified information regarding the reimbursement rates paid under the Medi-Cal program, and would allow the department to utilize up to a total of $600,000 of certain funds appropriated in the Budget Act of 2006 for these purposes.

The bill would authorize the California Health and Human Services Agency to implement a plan to improve the state's ability to respond to a public health emergency, and would require the agency, in consultation with the Office of Emergency Services, to report, on a quarterly basis commencing October 1, 2006, to the appropriate fiscal and policy committees of the Legislature, on the state's progress. It would require the agency, by November 15, 2006, to provide to those committees of the Legislature the state's plan for the new health care delivery response system.

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 1300 of the Business and Professions Code is amended to read:

1300. The amount of application, registration, and license fees under this chapter shall be as follows:

(a) The application fee for a histocompatibility laboratory director's, clinical laboratory bioanalyst's, clinical chemist's, clinical

microbiologist's, clinical laboratory toxicologist's, clinical cytogeneticist's, or clinical molecular biologist's license is thirty-eight dollars ($38). This fee shall be sixty-three dollars ($63) commencing on July 1, 1983.

(b) The annual renewal fee for a histocompatibility laboratory director's, clinical laboratory bioanalyst's, clinical chemist's, clinical microbiologist's, or clinical laboratory toxicologist's license is thirty-eight dollars ($38). This fee shall be sixty-three dollars ($63) commencing on July 1, 1983.

(c) The application fee for a clinical laboratory scientist's or limited clinical laboratory scientist's license is twenty-three dollars ($23). This fee shall be thirty-eight dollars ($38) commencing on July 1, 1983.

(d) The application and annual renewal fee for a cytotechnologist's license shall be fifty dollars ($50) commencing on January 1, 1991.

(e) The annual renewal fee for a clinical laboratory scientist's or limited clinical laboratory scientist's license is fifteen dollars ($15). This fee shall be twenty-five dollars ($25) commencing on July 1, 1983.

(f) The application fee for a clinical laboratory license is six hundred dollars ($600).

(g) The annual renewal fee for a clinical laboratory license is five hundred fifty-seven dollars ($557).

(h) The application fee for a certificate of accreditation issued pursuant to Section 1223 is one hundred fifty dollars ($150).

(i) The annual renewal fee for a certificate of accreditation issued pursuant to Section 1223 is one hundred dollars ($100).

(j) In addition, clinical laboratories providing cytology services shall pay an annual fee that shall be set by the department in an amount needed to meet but not exceed the department's costs of proficiency testing and special site surveys for these laboratories, and that shall be based upon the volume of cytologic slides examined by a laboratory. If the amount collected is less than or exceeds the amount needed for these purposes, the amount of fees collected from those laboratories in the following year shall be adjusted accordingly.

(k) The application fee for a trainee's license is eight dollars ($8). This fee shall be thirteen dollars ($13) commencing on July 1, 1983.

(*l*) The annual renewal fee for a trainee's license is five dollars ($5). This fee shall be eight dollars ($8) commencing on July 1, 1983.

(m) The application fee for a duplicate license is three dollars ($3). This fee shall be five dollars ($5) commencing on July 1, 1983.

(n) The delinquency fee is equal to the annual renewal fee.

(o) The director may establish a fee for examinations required under this chapter. The fee shall not exceed the total cost to the department in conducting the examination.

(p) The annual fee for a clinical laboratory subject to registration under paragraph (2) of subdivision (a) of Section 1265 and performing only those clinical laboratory tests or examinations considered waived under CLIA is fifty dollars ($50). The annual fee for a clinical laboratory subject

to registration under paragraph (2) of subdivision (a) of Section 1265 and performing only provider-performed microscopy, as defined under CLIA is seventy-five dollars ($75). A clinical laboratory performing both waived and provider-performed microscopy shall pay an annual registration fee of seventy-five dollars ($75).

(q) The costs of the department in conducting a complaint investigation, imposing sanctions, or conducting a hearing under this chapter shall be paid by the clinical laboratory. The fee shall be no greater than the fee the laboratory would pay under CLIA for the same type of activities and shall not be payable if the clinical laboratory would not be required to pay those fees under CLIA.

(r) The state, a district, city, county, city and county, or other political subdivision, or any public officer or body shall be subject to the payment of fees established pursuant to this chapter or regulations adopted thereunder.

(s) In addition to the payment of registration or licensure fees, a clinical laboratory located outside the State of California shall reimburse the department for travel and per diem to perform any necessary onsite inspections at the clinical laboratory in order to ensure compliance with this chapter.

(t) Whenever a clinical laboratory has paid registration or compliance fees, or both, to HCFA under CLIA for the same period of time for which a license is issued under Section 1265, the fee required for the clinical laboratory license under subdivision (f) or (g), and as adjusted pursuant to Section 100450 of the Health and Safety Code, shall be reduced by the percentage of the total of all CLIA registration and compliance fees paid to HCFA by all California laboratories that are made available to the department to carry out its functions as a CLIA agent in the federal fiscal year immediately prior to when the license fee is due.

(u) The department shall establish an application fee and a renewal fee for a medical laboratory technician license, the total fees collected not to exceed the costs of the department for the implementation and operation of the program licensing and regulating medical laboratory technicians pursuant to Section 1260.3.

SEC. 2. Section 1214 of the Health and Safety Code is amended to read:

1214. Each application under this chapter for an initial license, renewal license, license upon change of ownership, or special permit shall be accompanied by a Licensing and Certification Program fee, as follows:

(a) For all primary care clinics licensed pursuant to this chapter, the annual fee shall be set in accordance with Section 1266.

(b) For all specialty clinics licensed pursuant to this chapter, the annual fee shall be set in accordance with Section 1266.

(c) For all rehabilitation clinics, the annual fee shall be set in accordance with Section 1266.

SEC. 3. Section 1214.1 of the Health and Safety Code is amended to read:

1214.1. Notwithstanding the provisions of Section 1214, each application for a surgical clinic or a chronic dialysis clinic under this chapter for an initial license, renewal license, license upon change of ownership, or special permit shall be accompanied by an annual Licensing and Certification Program fee set in accordance with Section 1266.

SEC. 4. Section 1214.5 of the Health and Safety Code is amended to read:

1214.5. Each application under this chapter for an initial license, renewal license, license upon change of ownership, or special permit for a psychology clinic shall be accompanied by a Licensing and Certification Program fee set in accordance with Section 1266.

SEC. 5. Section 1266 of the Health and Safety Code is repealed.

SEC. 6. Section 1266 is added to the Health and Safety Code, to read:

1266. (a) Unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation, the Licensing and Certification Division shall, no later than the beginning of the 2009–10 fiscal year, be supported entirely by federal funds and special funds.

(b) The Licensing and Certification Program fees for the 2006–07 fiscal year shall be as follows:

Type of Facility	Fee	
General Acute Care Hospitals	$ 134.10	per bed
Acute Psychiatric Hospitals	$ 134.10	per bed
Special Hospitals	$ 134.10	per bed
Chemical Dependency Recovery Hospitals	$ 123.52	per bed
Skilled Nursing Facilities	$ 202.96	per bed
Intermediate Care Facilities	$ 202.96	per bed
Intermediate Care Facilities - Developmentally Disabled	$ 592.29	per bed
Intermediate Care Facilities - Developmentally Disabled - Habilitative	$1,000.00	per facility
Intermediate Care Facilities - Developmentally Disabled - Nursing	$1,000.00	per facility
Home Health Agencies	$2,700.00	per facility
Referral Agencies	$5,537.71	per facility
Adult Day Health Centers	$4,650.02	per facility
Congregate Living Health Facilities	$ 202.96	per bed
Psychology Clinics	$ 600.00	per facility
Primary Clinics - Community and Free	$ 600.00	per facility
Specialty Clinics - Rehab Clinics		
(For profit)	$2,974.43	per facility
(Nonprofit)	$ 500.00	per facility
Specialty Clinics - Surgical and Chronic	$1,500.00	per facility
Dialysis Clinics	$1,500.00	per facility
Pediatric Day Health/Respite Care	$ 142.43	per bed
Alternative Birthing Centers	$2,437.86	per facility

Hospice	$1,000.00	per facility
Correctional Treatment Centers	$ 590.39	per bed

(c) Commencing February 1, 2007, and every February 1 thereafter, the department shall publish a list of estimated fees pursuant to this section. The calculation of estimated fees and the publication of the report and list of estimated fees shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) By February 1 of each year, the department shall prepare the following reports and shall make those reports, and the list of estimated fees required to be published pursuant to subdivision (c), available to the public by submitting them to the Legislature and posting them on the department's Internet Web site:

(1) The department shall prepare a report of all costs for activities of the Licensing and Certification Program. As part of this report, the department shall recommend Licensing and Certification Program fees in accordance with the following:

(A) Projected workload and costs shall be grouped for each fee category.

(B) Cost estimates, and the estimated fees, shall be based on the appropriation amounts in the Governor's proposed budget for the next fiscal year, with and without policy adjustments to the fee methodology.

(C) The allocation of program, operational, and administrative overhead, and indirect costs to fee categories shall be based on generally accepted cost allocation methods. Significant items of costs shall be directly charged to fee categories if the expenses can be reasonably identified to the fee category that caused them. Indirect and overhead costs shall be allocated to all fee categories using a generally accepted cost allocation method.

(D) The amount of federal funds and General Fund moneys to be received in the budget year shall be estimated and allocated to each fee category based upon an appropriate metric.

(E) The fee for each category will be determined by dividing the aggregate state share of all costs for the Licensing and Certification Program by the appropriate metric for the category of licensure.

(2) (A) The department shall prepare a staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development.

(B) The analysis under this paragraph shall be made available to interested persons and shall include all of the following:

(i) The number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities.

(ii) The percentage of time devoted to licensing and certification activities for the various types of health facilities.

(iii) The number of facilities receiving full surveys and the frequency and number of follow up visits.

(iv) The number and timeliness of complaint investigations.

(v) Data on deficiencies and citations issued, and numbers of citation review conferences and arbitration hearings.

(vi) Other applicable activities of the licensing and certification division.

(e) (1) The department shall adjust the list of estimated fees published pursuant to subdivision (c) if the annual Budget Act or other enacted legislation includes an appropriation that differs from those proposed in the Governor's proposed budget for that fiscal year.

(2) The department shall publish a final fee list, with an explanation of any adjustment, by the issuance of an all facilities letter, by posting the list on the department's Internet Web site, and by including the final fee list as part of the licensing application package, within 14 days of the enactment of the annual Budget Act. The adjustment of fees and the publication of the final fee list shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) (1) No fees shall be assessed or collected pursuant to this section from any state department, authority, bureau, commission, or officer, unless federal financial participation would become available by doing so and an appropriation is included in the annual Budget Act for that state department, authority, bureau, commission, or officer for this purpose. No fees shall be assessed or collected pursuant to this section from any clinic that is certified only by the federal government and is exempt from licensure under Section 1206, unless federal financial participation would become available by doing so.

(2) For the 2006–07 state fiscal year, no fee shall be assessed or collected pursuant to this section from any general acute care hospital owned by a health care district with 100 beds or less.

(g) The Licensing and Certification Program may change annual license expiration renewal dates to provide for efficiencies in operational processes or to provide for sufficient cash flow to pay for expenditures. If an annual license expiration date is changed, the renewal fee shall be prorated accordingly. Facilities shall be provided with a 60-day notice of any change in their annual license renewal date.

SEC. 7. Section 1266.5 is added to the Health and Safety Code, to read:

1266.5. (a) Whenever any entity required to pay fees pursuant to Section 1266 continues to operate beyond its license expiration date, without the Licensing and Certification Program renewal fees first having been paid as required by this division, those fees are delinquent.

(b) A late payment penalty shall be added to any delinquent fees due with an application for license renewal made later than midnight of the

license expiration date. The late payment penalty shall be computed as follows:

(1) For a delinquency period of 30 days or less, the penalty shall be 10 percent of the fee.

(2) For a delinquency period of more than 30 days to and including 60 days, the penalty shall be 20 percent of the fee.

(3) For a delinquency period of more than 60 days, the penalty shall be 60 percent of the fee.

(c) The department may, upon written notification to the licensee, offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the department, to recoup the license renewal fee and any associated late payment penalties.

(d) No license may be renewed without payment of the Licensing and Certification Program fee plus any late payment penalty.

SEC. 8. Section 1266.7 is added to the Health and Safety Code, to read:

1266.7. The annual Licensing and Certification Program fee for a congregate living health facility shall be set in accordance with Section 1266.

SEC. 9. Section 1266.9 is added to the Health and Safety Code, to read:

1266.9. There is established within the Special Deposit Fund the Department of Health Services, Licensing and Certification Program Account. The revenue collected in accordance with Section 1266 shall be deposited in the Licensing and Certification Program Account and shall be available for expenditure upon appropriation to support the Licensing and Certification Program's operation. Interest earned on the funds in the Licensing and Certification Program Account shall be deposited as revenue into the Account to support the Licensing and Certification Program's operation.

SEC. 10. Section 1266.10 is added to the Health and Safety Code, to read:

1266.10. The amount of three million two hundred four thousand three hundred seventy dollars ($3,204,370) is appropriated from the General Fund to the State Department of Health Services, for a loan for use to support the operations of the Licensing and Certification Program. Repayment of this loan shall be made with proceeds from fees collected pursuant to Section 1266, in three equal annual installments of one million sixty-eight thousand one hundred twenty-three dollars ($1,068,123), commencing on July 1, 2007, or upon the enactment of the Budget Act of 2007, whichever is later.

SEC. 11. Section 1266.12 is added to the Health and Safety Code, to read:

1266.12. (a) The annual Licensing and Certification Program fee for a skilled nursing facility, intermediate care facility, general acute care hospital, acute psychiatric hospital, special hospital, chemical dependency recovery hospital, correctional treatment center, intermediate care

facility/developmentally disabled, intermediate care facility/developmentally disabled nursing, and intermediate care facility/developmentally disabled habilitative shall be set in accordance with Section 1266.

(b) Commencing January 1, 2007, the department shall give priority in conducting initial licensing surveys to each intermediate care facility/developmentally disabled, intermediate care facility/developmentally disabled habilitative, and intermediate care facility/developmentally disabled nursing. Upon successful completion of licensure, and upon notification by the facility that it is ready for an initial certification survey, the department shall schedule and initiate a certification survey within 60 days.

SEC. 12. Section 1337.6 of the Health and Safety Code is amended to read:

1337.6. (a) Certificates issued under this article shall be renewed every two years and renewal shall be conditional upon the occurrence of all of the following:

(1) The certificate holder submitting documentation of completion of 48 hours of in-service training every two years obtained through an approved training program or taught by a director of staff development for a licensed skilled nursing or intermediate care facility that has been approved by the department, or by individuals or programs approved by the department. At least 12 of the 48 hours of in-service training shall be completed in each of the two years. Twenty-four of the 48 hours of in-service training may be obtained through an online computer training program approved by the Licensing and Certification Division of the department.

(2) (A) A vendor of online programs for continuing education shall ensure that each online course contains all of the following:

(i) An interactive portion where the participants receive feedback, through online communication, based on input from the participant.

(ii) Required use of a personal identification number or personal identification information to confirm the identity of the participant.

(iii) A final screen displaying a printable statement, to be signed by the participant, certifying that the identified participant completed the course. The vendor shall obtain a copy of the final screen statement with the original signature of the participant prior to the issuance of a certificate of completion. The signed statement of completion shall be maintained by the vendor for a period of three years and shall be made available to the department upon demand.

(B) The department may approve online programs for continuing education that do not meet the requirements of subparagraph (A) if the vendor demonstrates to the department’s satisfaction that, through advanced technology, the course and the course delivery meet the other requirements of this section.

(3) The certificate holder obtaining a criminal record clearance.

(b) Certificates issued under this article shall expire on the certificate holder's birthday.

(c) To renew an unexpired certificate, the certificate holder shall, on or before the certificate expiration date, apply for renewal on a form provided by the department and submit documentation of the required in-service training.

(d) The department shall give written notice to a certificate holder 90 days in advance of the renewal date and, 90 days in advance of the expiration of the fourth year that a renewal application has not been submitted, and shall give written notice informing the certificate holder, in general terms, of the provisions of this article. Nonreceipt of the renewal notice does not relieve the certificate holder of the obligation to make a timely renewal. Failure to make a timely renewal shall result in expiration of the certificate.

(e) Except as otherwise provided in this article, an expired certificate may be renewed at any time within two years after its expiration on the filing of an application for renewal on a form prescribed by the department and documentation of the required in-service education.

Renewal under this article shall be effective on the date on which the application is filed. If so renewed, the certificate shall continue in effect until the date provided for in this article, when it shall expire if it is not again renewed.

(f) If a certified nurse assistant applies for renewal more than two years after the expiration, the certified nurse assistant shall complete an approved 75-hour competency evaluation training program and competency evaluation program. A suspended certificate is subject to expiration and shall be renewed as provided in this article, but this renewal does not entitle the certificate holder, while the certificate remains suspended, and, until it is reinstated, to engage in the certified activity, or in any other activity or conduct in violation of the order or judgment by which the certificate was suspended.

(g) A revoked certificate is subject to expiration as provided in this article, but it cannot be renewed.

(h) Except as provided in subdivision (i), a certificate that is not renewed within four years after its expiration cannot be renewed, restored, reissued, or reinstated except upon completion of a certification program unless deemed otherwise by the department if both of the following conditions are met:

(1) No fact, circumstance, or condition exists that, if the certificate was issued, would justify its revocation or suspension.

(2) The person takes and passes any examination that may be required of an applicant for a new certificate at that time, that shall be given by an approved provider of a certification training program.

(i) A certified nurse assistant whose certificate has expired after two years may have his or her certificate renewed if he or she completes 75 hours in an approved competency evaluation training program, passes a competency test, and obtains a criminal background clearance prior to the

renewal. The department shall develop a training program for these previously certified individuals.

(j) Certificate holders shall notify the department within 60 days of any change of address. Any notice sent by the department shall be effective if mailed to the current address filed with the department.

(k) Certificate holders that have been certified as both nurse assistants pursuant to this article and home health aides pursuant to Chapter 8 (commencing with Section 1725) of Division 2 shall renew their certificates at the same time on one application.

SEC. 13. Section 1337.7 of the Health and Safety Code is repealed.

SEC. 14. Section 1338.5 of the Health and Safety Code is amended to read:

1338.5. (a) (1) A criminal record clearance shall be conducted for all nurse assistants by the submission of fingerprint cards to the state department for processing at the Department of Justice. This criminal record clearance shall be completed prior to issuing or renewing a certificate. The fee to cover the processing costs of the Department of Justice, not including the costs associated with rolling the fingerprint cards, shall not exceed thirty-two dollars ($32) per card.

(2) Upon enrollment in a training program for nurse assistant certification, and prior to direct contact with residents, a candidate for training shall submit a training and examination application and the fingerprint cards to the state department to receive a criminal record review through the Department of Justice. Submission of the fingerprints to the Federal Bureau of Investigation shall be at the discretion of the state department.

(3) Each health facility that operates and is used as a clinical skills site for certification training, and each health facility, prior to hiring a nurse assistant applicant certified in another state or country, shall arrange for and pay the cost of the fingerprint live-scan service and the Department of Justice processing costs for each applicant. Health facilities may not pass these costs through to nurse assistant applicants unless allowed by federal law enacted subsequent to the effective date of this paragraph.

(b) Upon receipt of the fingerprints, the Department of Justice shall notify the state department of the criminal record information, as provided for in this subdivision. If no criminal record information has been recorded, the Department of Justice shall provide the state department with a statement of that fact. If the fingerprints are illegible, the Department of Justice shall, within 15 calendar days from receipt of the fingerprints, notify the state department of that fact.

(c) The department shall respond to the applicant and employer within 30 days from the date of receipt of the fingerprint cards.

(d) The use of fingerprint live-scan technology implemented by the Department of Justice by the year 1999 shall be used by the Department of Justice to generate timely and accurate positive fingerprint identification prior to nurse assistant certification.

(e) The state department shall develop procedures to ensure that any licensee, direct care staff, or certificate holder for whom a criminal record has been obtained pursuant to this section or Section 1265.5 or 1736 shall not be required to obtain multiple criminal record clearances.

(f) If the department receives a fingerprint card from a certified nursing assistant 60 days prior to the expiration of the certified nursing assistant's certification and the department has received no response from the Department of Justice, or if the department is experiencing a delay in processing the renewal of the certified nursing assistant's certification at the time of the expiration of the certified nursing assistant's certification, the department may extend the expiration of the certified nursing assistant's certification for 60 days. This provision shall expire August 1, 2001.

SEC. 15. Section 1403 of the Health and Safety Code is amended to read:

1403. Each application for a license or renewal of license under this chapter shall be accompanied by an annual Licensing and Certification Program fee set in accordance with Section 1266. Each license shall expire 12 months from its date of issuance and application for renewal accompanied by the fee shall be filed with the director not later than 30 days prior to the date of expiration.

SEC. 16. Section 1403.1 of the Health and Safety Code is repealed.

SEC. 17. Section 1575.9 of the Health and Safety Code is amended to read:

1575.9. Each application for a new license or renewal submitted to the state department shall be accompanied by an annual Licensing and Certification Program fee set in accordance with Section 1266.

SEC. 18. Section 1729 of the Health and Safety Code is amended to read:

1729. Each application for a license under this chapter, except applications by the State of California or any state department, authority, bureau, commission, or officer, shall be accompanied by a Licensing and Certification Program fee for the headquarters or main office of the agency and for each additional branch office maintained and operated by the agency in the amount set in accordance with Section 1266.

SEC. 19. Section 1729.1 of the Health and Safety Code is repealed.

SEC. 20. Section 1730 of the Health and Safety Code is amended to read:

1730. Each license issued under this chapter shall expire 12 months from the date of its issuance. Application for renewal of license accompanied by the necessary fee shall be filed with the state department annually, not less than 30 days prior to expiration date. Failure to make a timely renewal shall result in expiration of the license.

SEC. 21. Section 1736.2 of the Health and Safety Code is amended to read:

1736.2. (a) Certificates issued for certified home health aides shall be renewed every two years and renewal shall be conditioned on the

certificate holder obtaining a criminal record clearance pursuant to Section 1736.6.

(b) Certificates issued to certified home health aides shall expire on the certificate holder's birthday.

(c) To renew an unexpired certificate, the certificate holder shall, on or before the certificate expiration date, apply for renewal on a form provided by the state.

(d) The department shall give written notice to a certificate holder 90 days in advance of the renewal date and 90 days in advance of the expiration of the fourth year that an application has not been submitted, and shall give written notice informing the certificate holder in general terms of the provisions governing certificate renewal for certified home health aides. Nonreceipt of the renewal notice does not relieve the certificate holder of the obligation to make a timely renewal. Failure to make a timely renewal shall result in expiration of the certificate.

(e) Except as otherwise provided in this article, an expired certificate may be renewed at any time within four years after its expiration on the filing of an application for renewal on a form prescribed by the department.

Renewal under this article shall be effective on the date on which the application is filed. If renewed, the certificate shall continue in effect until the date provided for in this section, when it shall expire if it is not again renewed.

(f) If a certified home health aide applies for renewal more than 30 days after expiration but within four years after the expiration, and demonstrates in writing to the department's satisfaction why the renewal application was late, then the state department shall issue a renewal. A suspended certificate is subject to expiration and shall be renewed as provided in this article, but this renewal does not entitle the certificate holder, while the certificate remains suspended, and until it is reinstated, to engage in the certified activity, or in any other activity or conduct in violation of the order or judgment by which the certificate was suspended.

(g) A revoked certificate is subject to expiration as provided in this section, but it cannot be renewed.

(h) A certificate that is not renewed within four years after its expiration cannot be renewed, restored, reissued, or reinstated except upon completion of a certification training program unless deemed otherwise by the state department if both of the following conditions are met:

(1) No fact, circumstance, or condition exists that, if the certificate were issued, would justify its revocation or suspension.

(2) The person takes and passes any examination that may be required of an applicant for a new certificate at that time, that shall be given by an approved provider of a certification training program.

(i) Certificate holders shall notify the department within 60 days of any change of address. Any notice sent by the department shall be effective if mailed to the current address filed with the department.

(j) Certificate holders that have been certified as both nurse assistants pursuant to Article 9 (commencing with Section 1337) of Chapter 2 of Division 2 and home health aides pursuant to this chapter shall renew their certificates at the same time on one application.

SEC. 22. Section 1736.3 of the Health and Safety Code is repealed.

SEC. 23. Section 1743.17 of the Health and Safety Code is amended to read:

1743.17. Each application for a private duty nursing agency license under this chapter, except applications by this state or any state department, authority, bureau, commission, or officer, shall be accompanied by a Licensing and Certification Program fee for the headquarters or main office of the agency and for each additional branch office maintained and operated by the agency in the amount set in accordance with Section 1266.

SEC. 24. Section 1743.19 of the Health and Safety Code is amended to read:

1743.19. Each private duty nursing agency license issued under this chapter shall expire 12 months from the date of its issuance. Application for renewal of license accompanied by the necessary fee shall be filed with the department annually, not less than 30 days prior to expiration date. Failure to make a timely renewal shall result in expiration of the license.

SEC. 25. Section 1750 of the Health and Safety Code is amended to read:

1750. (a) Each new and renewal application for a license under this chapter shall be accompanied by an annual Licensing and Certification Program fee set in accordance with Section 1266.

(b) All hospices shall maintain compliance with the licensing requirements. These requirements shall not, however, prohibit the use of alternate concepts, methods, procedures, techniques, space, equipment, personnel qualifications, or the conducting of pilot projects, necessary for program flexibility. Program flexibility shall be carried out with provision for safe and adequate patient care and with prior written approval of the state department. A written request for program flexibility and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the state department. The state department shall approve or deny the request within 60 days of submission. Approval shall be in writing and shall provide for the terms and conditions under which program flexibility is approved. A denial shall be in writing and shall specify the basis therefor. If after investigation the state department determines that a hospice using program flexibility pursuant to this section is operating in a manner contrary to the terms or conditions of the approval for program flexibility, the director shall immediately revoke that approval.

(c) Each hospice shall, on or before March 15 of each year, file with the Office of Statewide Health Planning and Development (OSHPD), upon forms furnished by OSHPD, a verified report for the preceding calendar year upon all matters requested by OSHPD. This report may include, but

not be limited to, data pertaining to age of patients, diagnostic categories of patients, and number of visits by service provided.

SEC. 26. Section 1760.5 is added to the Health and Safety Code, to read:

1760.5. The annual Licensing and Certification Program fee for a pediatric day health and respite care facility, as defined in Section 1760.2, shall be set in accordance with Section 1266.

SEC. 27. Section 1794.06 of the Health and Safety Code is amended to read:

1794.06. Each application for a license under this chapter shall be accompanied by a Licensing and Certification Program fee set in accordance with Section 1266.

SEC. 28. Section 100445 of the Health and Safety Code is repealed.

SEC. 29. Section 100922 of the Health and Safety Code is amended to read:

100922. (a) Notwithstanding any other provision of law, a freestanding cardiac catheterization laboratory that as of December 31, 1993, was in active status in the Health Care Pilot Project established pursuant to former Part 1.85 (commencing with Section 444) of Division 1, and that meets the requirements specified in this section, may be licensed by the State Department of Health Services as a freestanding cardiac catheterization laboratory. The license shall be subject to suspension or revocation, or both, in accordance with Article 5 (commencing with Section 1240) of Chapter 1 of Division 2. An application for licensure or annual renewal shall be accompanied by a Licensing and Certification Program fee set in accordance with Section 1266.

(b) A laboratory granted a license pursuant to this section shall be subject to the department's regulations that govern cardiac catheterization laboratories operating in hospitals without facilities for cardiac surgery, any similar regulations that may be developed by the department specifically to govern freestanding cardiac catheterization laboratories, and to the following regulations: subdivisions (a) and (d) of Section 70129 of; paragraphs (1), (2), (3), and (4) of subdivision (a) of, and subdivision (i) of Section 70433 of; paragraphs (1), (3), (4), and (5) of subdivision (a) of Section 70435 of; subparagraphs (A), (B), and (D) of paragraph (1) of, and paragraphs (5) and (7) of, subdivision (b) of Section 70437 of; subdivision (a) of Section 70439 of; Sections 70841, 75021, and 75022 of; subdivision (a) of Section 75023 of; Sections 75024, 75025, and 75026 of; subdivisions (a), (b), and (c) of Section 75027 of; subdivision (b) of Section 75029 of; Section 75030 of; subdivision (b) of Section 75031 of; Sections 75034, 75035, 75037, 75039, 75045, and 75046 of; subdivision (a) of Section 75047 of; and Sections 75050, 75051, 75052, 75053, 75054, 75055, 75057, 75059, 75060, 75061, 75062, 75063, 75064, 75065, 75066, 75071, and 75072 of; Title 22 of the California Code of Regulations.

(c) A laboratory granted a license pursuant to this section shall have a system for the ongoing evaluation of its operations and the services it

provides. This system shall include a written plan for evaluating the efficiency and effectiveness of the health care services provided that describes the following:

(1) The scope of the services provided.

(2) Measurement indicators regarding the processes and outcomes of the services provided.

(3) The assignment of responsibility when the data from the measurement indicators demonstrates the need for action.

(4) A mechanism to ensure followup evaluation of the effectiveness of the actions taken.

(5) An annual evaluation of the plan.

(d) A laboratory granted a license pursuant to this section is authorized to perform only the following diagnostic procedures:

(1) Right heart catheterization or angiography, or both.

(2) Left heart catheterization or angiography, or both.

(3) Coronary catheterization and angiography.

(4) Electrophysiology studies.

(e) A laboratory granted a license pursuant to this section shall only perform its procedures on adults, on an outpatient basis. Each laboratory shall define patient characteristics that are appropriate for safe performance of procedures in the laboratory, and include evaluation of these criteria in its quality assurance process.

(f) Notwithstanding the requirements already set forth in this chapter, freestanding cardiac catheterization laboratories shall comply with all other applicable federal, state, and local laws.

(g) This section shall become operative on January 1, 1995, and does not require the department to adopt regulations.

SEC. 30. Section 101315.2 is added to the Health and Safety Code, to read:

101315.2. Of the sixteen million dollars ($16,000,000) appropriated in the Budget Act of 2006 for local health jurisdictions for the purpose of preparing California for public health emergencies, including a potential pandemic influenza event, a baseline allocation of one hundred twenty-five thousand dollars ($125,000) shall be provided to each local health jurisdiction first, with the remaining amount allocated on a per population basis using the population information possessed by the Department of Finance.

SEC. 31. Section 103526 of the Health and Safety Code is amended to read:

103526. (a) If the State Registrar, local registrar, or county recorder receives a written or faxed request for a certified copy of a birth or death record pursuant to Section 103525, or a military service record pursuant to Section 6107 of the Government Code, that is accompanied by a notarized statement sworn under penalty of perjury, or a faxed copy of a notarized statement sworn under penalty of perjury, that the requester is an authorized person, as defined in this section, that official may furnish a certified copy to the applicant in accordance with Section 103525 and in

accordance with Section 6107 of the Government Code. If a written request for a certified copy of a military service record is submitted to a county recorder by fax, the county recorder may furnish a certified copy of the military record to the applicant in accordance with Section 103525. A faxed notary acknowledgment accompanying a faxed request received pursuant to this subdivision for a certified copy of a birth or death record or a military service record shall be legible and, if the notary's seal is not photographically reproducible, show the name of the notary, the county of the notary's principal place of business, the notary's telephone number, the notary's registration number, and the notary's commission expiration date typed or printed in a manner that is photographically reproducible below, or immediately adjacent to, the notary's signature in the acknowledgment. If a request for a certified copy of a birth or death record is made in person, the official shall take a statement sworn under penalty of perjury that the requester is signing his or her own legal name and is an authorized person, and that official may then furnish a certified copy to the applicant.

(b) In all other circumstances, the certified copy provided to the applicant shall be an informational certified copy and shall display a legend that states "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY." The legend shall be placed on the certificate in a manner that will not conceal information.

(c) For purposes of this section, an "authorized person" is any of the following:

(1) The registrant or a parent or legal guardian of the registrant.

(2) A party entitled to receive the record as a result of a court order, or an attorney or a licensed adoption agency seeking the birth record in order to comply with the requirements of Section 3140 or 7603 of the Family Code.

(3) A member of a law enforcement agency or a representative of another governmental agency, as provided by law, who is conducting official business.

(4) A child, grandparent, grandchild, sibling, spouse, or domestic partner of the registrant.

(5) An attorney representing the registrant or the registrant's estate, or any person or agency empowered by statute or appointed by a court to act on behalf of the registrant or the registrant's estate.

(6) Any agent or employee of a funeral establishment who acts within the course and scope of his or her employment and who orders certified copies of a death certificate on behalf of any individual specified in paragraphs (1) to (5), inclusive, of subdivision (a) of Section 7100.

(d) Any person who asks the agent or employee of a funeral establishment to request a death certificate on his or her behalf warrants the truthfulness of his or her relationship to the decedent, and is personally liable for all damages occasioned by, or resulting from, a breach of that warranty.

(e) Notwithstanding any other provision of law:

(1) Any member of a law enforcement agency or a representative of a state or local government agency, as provided by law, who orders a copy of a record to which subdivision (a) applies in conducting official business may not be required to provide the notarized statement required by subdivision (a).

(2) An agent or employee of a funeral establishment who acts within the course and scope of his or her employment and who orders death certificates on behalf of individuals specified in paragraphs (1) to (5), inclusive, of subdivision (a) of Section 7100 shall not be required to provide the notarized statement required by subdivision (a).

(f) Informational certified copies of birth and death certificates issued pursuant to subdivision (b) shall only be printed from the single statewide database prepared by the State Registrar and shall be electronically redacted to remove any signatures for purposes of compliance with this section. Local registrars and county recorders shall not issue informational certified copies of birth and death certificates from any source other than the statewide database prepared by the State Registrar. This subdivision shall become operative on July 1, 2007, but only after the statewide database becomes operational and the full calendar year of the birth and death indices and images is entered into the statewide database and is available for the respective year of the birth or death certificate for which an informational copy is requested. The State Registrar shall provide written notification to local registrars and county recorders as soon as a year becomes available for issuance from the statewide database.

SEC. 32. Section 103526.5 of the Health and Safety Code is amended to read:

103526.5. (a) Each certified copy of a birth or death record issued pursuant to Section 103525 shall include the date issued, the name of the issuing officer, the signature of the issuing officer, whether that is the State Registrar, local registrar, county recorder, or county clerk, or an authorized facsimile thereof, and the seal of the issuing office.

(b) (1) All certified copies of birth and death records issued pursuant to Section 103525 shall be printed on chemically sensitized security paper that measures 8 ½ by 11 inches and that has the following features:

(A) Intaglio print.
(B) Latent image.
(C) Fluorescent, consecutive numbering with matching barcode.
(D) Microprint line.
(E) Prismatic printing.
(F) Watermark.
(G) Void pantograph.
(H) Fluorescent security threads.
(I) Fluorescent fibers.
(J) Any other security features deemed necessary by the State Registrar.

(2) In addition to the security features required by paragraph (1), commencing January 1, 2009, the security paper used for informational certified copies of birth and death records pursuant to subdivision (b) of

Section 103526 shall also contain a statement in perforated type that states "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY."

(c) The State Registrar, local registrars, county recorders, and county clerks shall take precautions to ensure that uniform and consistent standards are used statewide to safeguard the security paper described in subdivision (b), including, but not limited to, the following measures:

(1) Security paper shall be maintained under secure conditions so as not to be accessible to the public.

(2) A log shall be kept of all visitors allowed in the area where security paper is stored.

(3) All spoilage shall be accounted for and subsequently destroyed by shredding on the premises.

SEC. 33. Section 107080 of the Health and Safety Code is amended to read:

107080. (a) The application fee for any certificate or permit issued pursuant to the Radiologic Technology Act (Section 27) shall be established by the department in an amount as it deems reasonably necessary to carry out the purpose of that act.

(b) The fee for any examination conducted pursuant to the Radiologic Technology Act (Section 27) after failure of that examination within the previous 12 months shall be fixed by the department in an amount it deems reasonably necessary to carry out that act.

(c) The annual renewal fee for each certificate or permit shall be fixed by the department in an amount it deems reasonably necessary to carry out the Radiologic Technology Act (Section 27).

(d) The penalty fee for renewal of any certificate or permit if application is made after its date of expiration shall be five dollars ($5) and shall be in addition to the fee for renewal prescribed by subdivision (c).

(e) The fee for a duplicate certificate or permit shall be one dollar ($1).

(f) No fee shall be required for a certificate or permit or a renewal thereof except as prescribed in the Radiologic Technology Act (Section 27).

SEC. 34. Section 111615 of the Health and Safety Code is amended to read:

111615. No person shall manufacture any drug or device in this state unless he or she has a valid license from the department. The license is valid for two calendar years from the date of issue, unless it is revoked. The license is not transferable.

The department may require any manufacturer, wholesaler, or importer of any prescription ophthalmic device in this state to obtain a license.

SEC. 35. Section 111625 of the Health and Safety Code is amended to read:

111625. A license application shall be completed biennially and accompanied by an application fee as prescribed in Section 111630. This fee is not refundable if the license is refused.

SEC. 36. Section 115065 of the Health and Safety Code is amended to read:

115065. (a) Notwithstanding Section 6103 of the Government Code, the department shall provide by regulation a schedule of the fees that shall be paid by the following persons:

(1) Persons possessing radioactive materials under licenses issued by the department or under other state or federal licenses for the use of these radioactive materials, when these persons use these radioactive materials in the state in accordance with the regulations adopted pursuant to subdivision (d) of Section 115060.

(2) Persons generally licensed for the use of devices and equipment utilizing radioactive materials that are designed and manufactured for the purpose of detecting, measuring, gauging, or controlling thickness, density, level, interface location, radiation, leakage, or qualitative or quantitative chemical composition, or for producing light or an ionized atmosphere, if the devices are manufactured pursuant to a specific license authorizing distribution to general licensees.

(b) The revenues derived from the fees shall be used, together with other funds made available therefor, for the purpose of the issuance of licenses or the inspection and regulation of the licensees.

(c) The department may adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to establish and adjust fees for radioactive materials licenses in an amount to produce estimated revenues equal to at least 95 percent of the department's costs in carrying out these licensing requirements, if the new fees were to remain in effect throughout the fiscal year for which the fee is established or adjusted.

(d) A local agency participating in a negotiated agreement pursuant to Section 114990 shall be fully reimbursed for direct and indirect costs based upon activities governed by Section 115070. With respect to these agreements, any salaries, benefits, and other indirect costs shall not exceed comparable costs of the department.

(e) The fees for licenses for radioactive materials and of devices and equipment utilizing those materials shall be adjusted annually pursuant to Section 100425.

(f) The department shall establish fees for followup inspections related to the failure to correct violations of this chapter or regulations adopted pursuant to this chapter. The fees established by the department may be charged for each inspection visit.

SEC. 37. Section 115080 of the Health and Safety Code is amended to read:

115080. (a) Notwithstanding Section 6103 of the Government Code, the department shall provide by regulation a ranking of priority for inspection, as determined by the degree of potentially damaging exposure of persons by ionizing radiation and the requirements of Section 115085, and a schedule of fees, based upon that priority ranking, that shall be paid by persons possessing sources of ionizing radiation that are subject to

registration in accordance with subdivisions (b) and (e) of Section 115060, and regulations adopted pursuant thereto. The revenues derived from the fees shall be used, together with other funds made available therefor, for the purpose of carrying out any inspections of the sources of ionizing radiation required by this chapter or regulations adopted pursuant thereto. The fees shall, together with any other funds made available to the department, be sufficient to cover the costs of administering this chapter, and shall be set in amounts intended to cover the costs of administering this chapter for each priority source of ionizing radiation. Revenues generated by the fees shall not offset any general funds appropriated for the support of the radiologic programs authorized pursuant to this chapter, and the Radiologic Technology Act (Section 27), and Chapter 7.6 (commencing with Section 114960). Persons who pay fees shall not be required to pay, directly or indirectly, for the share of the costs of administering this chapter of those persons for whom fees are waived. The department shall take into consideration any contract payment from the Health Care Financing Administration for performance of inspections for Medicare certification and shall reduce this fee accordingly.

(b) A local agency participating in a negotiated agreement pursuant to Section 114990 shall be fully reimbursed for direct and indirect costs based upon activities governed by Section 115085. With respect to these agreements, any salaries, benefits, and other indirect costs shall not exceed comparable costs of the department. Any changes in the frequency of inspections or the level of reimbursement to local agencies made by this section or Section 115085 during the 1985–86 Regular Session shall not affect ongoing contracts.

(c) The fees paid by persons possessing sources of ionizing radiation shall be adjusted annually pursuant to Section 100425.

(d) The department shall establish two different registration fees for mammography equipment pursuant to this section based upon whether the equipment is accredited by an independent accrediting agency recognized under the federal Mammography Quality Standards Act (42 U.S.C. Sec. 263b).

(e) The department shall establish fees for followup inspections related to the failure to correct violations of this chapter or regulations adopted pursuant to this chapter. The fees established by the department may be charged for each inspection visit.

SEC. 38. Section 117971 is added to the Health and Safety Code, to read:

117971. In addition to the fees collected pursuant to Section 117995, the department, in the implementation of this part, shall recover its actual costs for services related to large quantity medical waste generator followup inspections and enforcement activities necessary to ensure compliance with this part. In no event shall the department charge more than the actual costs incurred by the department.

SEC. 39. Section 117995 of the Health and Safety Code is amended to read:

117995. The registration and annual permit fee for large quantity generators shall be set in following amounts:

(a) (1) A general acute care hospital, as defined in subdivision (a) of Section 1250, that has one or more beds, but not more than 99 beds, shall pay six hundred dollars ($600), a facility with 100 or more beds, but not more than 199 beds, shall pay eight hundred sixty dollars ($860), a facility with 200 or more beds, but not more than 250 beds shall pay one thousand one hundred dollars ($1,100), and a facility with 251 or more beds shall pay one thousand four hundred dollars ($1,400).

(2) In addition to the fees specified in paragraph (1), a general acute care hospital which is providing onsite treatment of medical waste shall pay an annual medical waste treatment facility inspection and permit fee of three hundred dollars ($300), if the facility has one or more beds but not more than 99 beds, five hundred dollars ($500), if the facility has 100 or more beds but not more than 250 beds, and one thousand dollars ($1,000), if the facility has 251 or more beds.

(b) A specialty clinic, providing surgical, dialysis, or rehabilitation services, as defined in subdivision (b) of Section 1204, shall pay three hundred fifty dollars ($350).

(c) A skilled nursing facility, as defined in subdivision (c) of Section 1250, that has one or more beds, but not more than 99 beds shall pay two hundred seventy-five dollars ($275), a facility with 100 or more beds, but not more than 199 beds shall pay three hundred fifty dollars ($350), and a facility with 200 or more beds shall pay four hundred dollars ($400).

(d) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250, shall pay two hundred dollars ($200).

(e) An intermediate care facility, as defined in subdivision (d) of Section 1250, shall pay three hundred dollars ($300).

(f) A primary care clinic, as defined in Section 1200.1, shall pay three hundred fifty dollars ($350).

(g) A licensed clinical laboratory, as defined in paragraph (3) of subdivision (a) of Section 1206 of the Business and Professions Code, shall pay two hundred dollars ($200).

(h) A health care service plan facility, as defined in subdivision (f) of Section 1345, shall pay three hundred fifty dollars ($350).

(i) A veterinary clinic or veterinary hospital shall pay two hundred dollars ($200).

(j) A large quantity generator medical office shall pay two hundred dollars ($200).

(k) In addition to the fees specified in subdivisions (b) to (j), inclusive, a large quantity generator of medical waste which is providing onsite treatment of medical waste shall pay an annual medical waste treatment facility inspection and permit fee of three hundred dollars ($300).

(*l*) The department may collect annual fees and issue permits on a biennial basis.

SEC. 40. Section 118210 of the Health and Safety Code is amended to read:

118210. (a) The department shall charge an annual permit fee for an offsite medical waste treatment facility equal to either one hundred twenty-seven ten thousandths of a cent ($0.0127) for each pound of medical waste treated or twelve thousand dollars ($12,000), whichever is greater. The department may collect annual fees and issue permits on a biennial basis.

(b) The department shall charge an initial application fee for each type of treatment technology at an offsite medical waste treatment facility equal to one hundred dollars ($100) for each hour the department spends processing the application, but not more than fifty thousand dollars ($50,000), or as provided in the regulations adopted by the department.

SEC. 41. Section 124977 of the Health and Safety Code is amended to read:

124977. (a) It is the intent of the Legislature that, unless otherwise specified, the program carried out pursuant to this chapter be fully supported from fees collected for services provided by the program.

(b) (1) The department shall charge a fee to all payers for any tests or activities performed pursuant to this chapter. The amount of the fee shall be established by regulation and periodically adjusted by the director in order to meet the costs of this chapter. Notwithstanding any other provision of law, any fees charged for prenatal screening and followup services provided to persons enrolled in the Medi-Cal program, health care service plan enrollees, or persons covered by health insurance policies, shall be paid in full directly to the Genetic Disease Testing Fund, subject to all terms and conditions of each enrollee's or insured's health care service plan or insurance coverage, whichever is applicable, including, but not limited to, copayments and deductibles applicable to these services, and only if these copayments, deductibles, or limitations are disclosed to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(2) The department shall expeditiously undertake all steps necessary to implement the fee collection process, including personnel, contracts, and data processing, so as to initiate the fee collection process at the earliest opportunity.

(3) The director shall convene, in the most cost-efficient manner and using existing resources, a working group comprised of health insurance, health care service plan, hospital, consumer, and department representatives to evaluate newborn and prenatal screening fee billing procedures, and recommend to the department ways to improve these procedures in order to improve efficiencies and enhance revenue collections for the department and hospitals. In performing its duties, the working group may consider models in other states. The working group shall make its recommendations by March 1, 2005.

(4) Effective for services provided on and after July 1, 2002, the department shall charge a fee to the hospital of birth, or, for births not occurring in a hospital, to families of the newborn, for newborn screening and followup services. The hospital of birth and families of newborns born

outside the hospital shall make payment in full to the Genetic Disease Testing Fund. The department shall not charge or bill Medi-Cal beneficiaries for services provided under this chapter.

(c) (1) The Legislature finds that timely implementation of changes in genetic screening programs and continuous maintenance of quality statewide services requires expeditious regulatory and administrative procedures to obtain the most cost-effective electronic data processing, hardware, software services, testing equipment, and testing and followup services.

(2) The expenditure of funds from the Genetic Disease Testing Fund for these purposes shall not be subject to Section 12102 of, and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of, the Public Contract Code, or to Division 25.2 (commencing with Section 38070). The department shall provide the Department of Finance with documentation that equipment and services have been obtained at the lowest cost consistent with technical requirements for a comprehensive high-quality program.

(3) The expenditure of funds from the Genetic Disease Testing Fund for implementation of the Tandem Mass Spectrometry screening for fatty acid oxidation, amino acid, and organic acid disorders, and screening for congenital adrenal hyperplasia may be implemented through the amendment of the Genetic Disease Branch Screening Information System contracts and shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and any policies, procedures, regulations or manuals authorized by those laws.

(4) The expenditure of funds from the Genetic Disease Testing Fund for the expansion of the Genetic Disease Branch Screening Information System to include cystic fibrosis and biotinidase may be implemented through the amendment of the Genetic Disease Branch Screening Information System contracts, and shall not be subject to Chapter 2 (commencing with Section 10290) or Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, or Sections 4800 to 5180, inclusive, of the State Administrative Manual as they relate to approval of information technology projects or approval of increases in the duration or costs of information technology projects. This paragraph shall apply to the design, development, and implementation of the expansion, and to the maintenance and operation of the Genetic Disease Branch Screening Information System, including change requests, once the expansion is implemented.

(d) (1) The department may adopt emergency regulations to implement and make specific this chapter in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act,

the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, these emergency regulations shall not be subject to the review and approval of the Office of Administrative Law. Notwithstanding Section 11346.1 and Section 11349.6 of the Government Code, the department shall submit these regulations directly to the Secretary of State for filing. The regulations shall become effective immediately upon filing by the Secretary of State. Regulations shall be subject to public hearing within 120 days of filing with the Secretary of State and shall comply with Sections 11346.8 and 11346.9 of the Government Code or shall be repealed.

(2) The Office of Administrative Law shall provide for the printing and publication of these regulations in the California Code of Regulations. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the regulations adopted pursuant to this chapter shall not be repealed by the Office of Administrative Law and shall remain in effect until revised or repealed by the department.

(3) The Legislature finds and declares that the health and safety of California newborns is in part dependent on an effective and adequately staffed genetic disease program, the cost of which shall be supported by the fees generated by the program.

SEC. 42. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child 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, except as specified in Section 12693.76.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In either of the following:

(i) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). Commencing July 1, 2007, eligibility under this subparagraph shall not include infants during any time they are enrolled in employer-sponsored health insurance or are subject to an exclusion pursuant to Section 12693.71 or 12693.72, or are enrolled in the full-scope of benefits under the Medi-Cal program at no share of cost. For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program, except during any time on or after July 1, 2007, that the infant is enrolled in employer-sponsored health insurance or is subject to an exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled in the full-scope of benefits under the Medi-Cal program at no share of cost. Except as otherwise specified in this section, this enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be disenrolled if the gross annual household income exceeds the income eligibility standard that was in effect in the Access for Infants and Mothers Program at the time the infant's mother became eligible, or following the two-month period established in Section 12693.981 if the infant is eligible for Medi-Cal with no share of cost. At the end of the second year, infants shall again be screened for program eligibility pursuant to this section, with income eligibility evaluated pursuant to clause (i), subparagraphs (B) and (C), and paragraph (2) of subdivision (a).

(B) All income over 200 percent of the federal poverty level but less than or equal to 250 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 250 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 250 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) The applicant shall agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant's signed statement as

to the value or amount of income shall be deemed to constitute verification.

(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

SEC. 43. Section 12695.03 is added to the Insurance Code, to read:

12695.03. "AIM-linked infant" means any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004.

SEC. 44. Section 12696.05 of the Insurance Code is amended to read:

12696.05. The board may do all of the following:

(a) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 12698.

(b) Determine the eligibility of applicants.

(c) Determine when subscribers are covered and the extent and scope of coverage.

(d) Determine subscriber contribution amounts schedules.

(1) Subscriber contribution amounts for care provided to the subscriber shall be indexed to the federal poverty level and shall not exceed 2 percent of a subscriber's annual gross family income.

(2) In addition to any other subscriber contribution specified in this subdivision, for subscribers enrolled on or after July 1, 2007, the board may also assess an additional subscriber contribution to cover the AIM-linked infant enrolled in the Healthy Families Program pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 for two months, using all applicable discounts pursuant to Section 12693.43.

(3) The board shall determine the manner in which the subscriber contributions are to be applied, including the order in which they are applied.

(e) Provide coverage through participating health plans or through coordination with other state programs, and contract for the processing of applications and the enrollment of subscribers. Any contract entered into pursuant to this part 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. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(f) Authorize expenditures from the fund to pay program expenses which exceed subscriber contributions, and to administer the program as necessary.

(g) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(h) Issue rules and regulations as necessary to administer the program. All rules and regulations issued pursuant to this subdivision that manage

program integrity, revise the benefit package, or reduce the eligibility criteria below 300 percent of the federal poverty level may be adopted as emergency regulations 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 adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(i) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

SEC. 45. Section 12699 of the Insurance Code is amended to read:

12699. (a) The Perinatal Insurance Fund is hereby created in the State Treasury.

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

(c) Notwithstanding Section 13340 of the Government Code, the fund is hereby continuously appropriated, without regard to fiscal years, to the board, for the purposes specified in this part.

(d) The board shall determine the portion of the subscriber contribution that shall be transferred from the Perinatal Insurance Fund to the Healthy Families Fund for the payment of the Healthy Families Program premium for the AIM-linked infant pursuant to paragraph (2) of subdivision (d) of Section 12696.05.

SEC. 46. Section 830.3 of the Penal Code is amended to read:

830.3. The following persons are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 of the Penal Code as to any public offense with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. These peace officers may carry firearms only if authorized and under those terms and conditions as specified by their employing agencies:

(a) Persons employed by the Division of Investigation of the Department of Consumer Affairs and investigators of the Medical Board of California and the Board of Dental Examiners, who are designated by the Director of Consumer Affairs, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code.

(b) Voluntary fire wardens designated by the Director of Forestry and Fire Protection pursuant to Section 4156 of the Public Resources Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 4156 of that code.

(c) Employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code, provided that the primary duty of these

peace officers shall be the enforcement of the law as that duty is set forth in Section 1655 of that code.

(d) Investigators of the California Horse Racing Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of this code.

(e) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 13104 of that code.

(f) Inspectors of the food and drug section designated by the chief pursuant to subdivision (a) of Section 106500 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 106500 of that code.

(g) All investigators of the Division of Labor Standards Enforcement designated by the Labor Commissioner, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Section 95 of the Labor Code.

(h) All investigators of the State Departments of Health Services, Social Services, Mental Health, and Alcohol and Drug Programs, the Department of Toxic Substances Control, the Office of Statewide Health Planning and Development, and the Public Employees' Retirement System, provided that the primary duty of these peace officers shall be the enforcement of the law relating to the duties of his or her department or office. Notwithstanding any other provision of law, investigators of the Public Employees' Retirement System shall not carry firearms.

(i) The Chief of the Bureau of Fraudulent Claims of the Department of Insurance and those investigators designated by the chief, provided that the primary duty of those investigators shall be the enforcement of Section 550.

(j) Employees of the Department of Housing and Community Development designated under Section 18023 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 18023 of that code.

(k) Investigators of the office of the Controller, provided that the primary duty of these investigators shall be the enforcement of the law relating to the duties of that office. Notwithstanding any other law, except as authorized by the Controller, the peace officers designated pursuant to this subdivision shall not carry firearms.

(*l*) Investigators of the Department of Corporations designated by the Commissioner of Corporations, provided that the primary duty of these investigators shall be the enforcement of the provisions of law administered by the Department of Corporations. Notwithstanding any

other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(m) Persons employed by the Contractors' State License Board designated by the Director of Consumer Affairs pursuant to Section 7011.5 of the Business and Professions Code, provided that the primary duty of these persons shall be the enforcement of the law as that duty is set forth in Section 7011.5, and in Chapter 9 (commencing with Section 7000) of Division 3, of that code. The Director of Consumer Affairs may designate as peace officers not more than three persons who shall at the time of their designation be assigned to the special investigations unit of the board. Notwithstanding any other provision of law, the persons designated pursuant to this subdivision shall not carry firearms.

(n) The Chief and coordinators of the Law Enforcement Division of the Office of Emergency Services.

(o) Investigators of the office of the Secretary of State designated by the Secretary of State, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Chapter 3 (commencing with Section 8200) of Division 1 of Title 2 of, and Section 12172.5 of, the Government Code. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(p) The Deputy Director for Security designated by Section 8880.38 of the Government Code, and all lottery security personnel assigned to the California State Lottery and designated by the director, provided that the primary duty of any of those peace officers shall be the enforcement of the laws related to assuring the integrity, honesty, and fairness of the operation and administration of the California State Lottery.

(q) Investigators employed by the Investigation Division of the Employment Development Department designated by the director of the department, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 317 of the Unemployment Insurance Code.

Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(r) The chief and assistant chief of museum security and safety of the California Science Center, as designated by the executive director pursuant to Section 4108 of the Food and Agricultural Code, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 4108 of the Food and Agricultural Code.

(s) Employees of the Franchise Tax Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of the law as set forth in Chapter 9 (commencing with Section 19701) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(t) Notwithstanding any other provision of this section, a peace officer authorized by this section shall not be authorized to carry firearms by his or her employing agency until that agency has adopted a policy on the use

of deadly force by those peace officers, and until those peace officers have been instructed in the employing agency's policy on the use of deadly force.

Every peace officer authorized pursuant to this section to carry firearms by his or her employing agency shall qualify in the use of the firearms at least every six months.

(u) Investigators of the Department of Managed Health Care designated by the Director of the Department of Managed Health Care, provided that the primary duty of these investigators shall be the enforcement of the provisions of laws administered by the Director of the Department of Managed Health Care. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(v) The Chief, Deputy Chief, supervising investigators, and investigators of the Office of Protective Services of the State Department of Developmental Services, provided that the primary duty of each of those persons shall be the enforcement of the law relating to the duties of his or her department or office.

SEC. 47. Section 4107 of the Welfare and Institutions Code is amended to read:

4107. (a) The security of patients committed pursuant to Section 1026 of, and Chapter 6 (commencing with Section 1367) of Title 10 of Part 2 of, the Penal Code, and former Sections 6316 and 6321 of the Welfare and Institutions Code, at Patton State Hospital shall be the responsibility of the Director of the Department of Corrections.

(b) The Department of Corrections and the State Department of Mental Health shall jointly develop a plan to transfer all patients committed to Patton State Hospital pursuant to the provisions in subdivision (a) from Patton State Hospital no later than January 1, 1986, and shall transmit this plan to the Senate Committee on Judiciary and to the Assembly Committee on Criminal Justice, and to the Senate Health and Welfare Committee and Assembly Health Committee by June 30, 1983. The plan shall address whether the transferred patients shall be moved to other state hospitals or to correctional facilities, or both, for commitment and treatment.

(c) Notwithstanding any other provision of law, the State Department of Mental Health shall house no more than 1,336 patients at Patton State Hospital. However, until September 2009, up to 1,530 patients may be housed at the hospital.

(d) The Department of Corrections and the State Department of Mental Health shall jointly develop a plan for ensuring the external and internal security of the hospital during the construction of additional beds at Patton State Hospital and the establishment of related modular program space for which funding is provided in the Budget Act of 2001. No funds shall be expended for the expansion project until 30 days after the date upon which the plan is submitted to the fiscal committees of the Legislature and the Chair of the Joint Legislative Budget Committee.

(e) The Department of Corrections and the State Department of Mental Health shall also jointly develop a plan for ensuring the external and internal security of the hospital upon the occupation of the additional beds at Patton State Hospital. These beds shall not be occupied by patients until the later of the date that is 30 days after the date upon which the plan is submitted to the Chair of the Joint Legislative Budget Committee or the date upon which it is implemented by the departments.

(f) This section shall remain in effect only until all patients committed, pursuant to the provisions enumerated in subdivision (a), have been removed from Patton State Hospital and shall have no force or effect on or after that date.

SEC. 48. Section 4640.6 of the Welfare and Institutions Code is amended to read:

4640.6. (a) In approving regional center contracts, the department shall ensure that regional center staffing patterns demonstrate that direct service coordination are the highest priority.

(b) Contracts between the department and regional centers shall require that regional centers implement an emergency response system that ensures that a regional center staff person will respond to a consumer, or individual acting on behalf of a consumer, within two hours of the time an emergency call is placed. This emergency response system shall be operational 24 hours per day, 365 days per year.

(c) Contracts between the department and regional centers shall require regional centers to have service coordinator-to-consumer ratios, as follows:

(1) An average service coordinator-to-consumer ratio of 1 to 62 for all consumers who have not moved from the developmental centers to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 79 consumers for more than 60 days.

(2) An average service coordinator-to-consumer ratio of 1 to 45 for all consumers who have moved from a developmental center to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 59 consumers for more than 60 days.

(3) Commencing January 1, 2004, to June 30, 2007, inclusive, the following coordinator-to-consumer ratios shall apply:

(A) All consumers three years of age and younger and for consumers enrolled on the Home and Community-based Services Waiver for persons with developmental disabilities, an average service coordinator-to-consumer ratio of 1 to 62.

(B) All consumers who have moved from a developmental center to the community since April 14, 1993, and have lived continuously in the community for at least 12 months, an average service coordinator-to-consumer ratio of 1 to 62.

(C) All consumers who have not moved from the developmental centers to the community since April 14, 1993, and who are not described

in subparagraph (A), an average service coordinator-to-consumer ratio of 1 to 66.

(4) For purposes of paragraph (3), service coordinators may have a mixed caseload of consumers three years of age and younger, consumers enrolled on the Home and Community-based Services Waiver program for persons with developmental disabilities, and other consumers if the overall average caseload is weighted proportionately to ensure that overall regional center average service coordinator-to-consumer ratios as specified in paragraph (3) are met. For purposes of paragraph (3), in no case shall a service coordinator have an assigned caseload in excess of 84 for more than 60 days.

(d) For purposes of this section, "service coordinator" means a regional center employee whose primary responsibility includes preparing, implementing, and monitoring consumers' individual program plans, securing and coordinating consumer services and supports, and providing placement and monitoring activities.

(e) In order to ensure that caseload ratios are maintained pursuant to this section, each regional center shall provide service coordinator caseload data to the department, annually for each fiscal year. The data shall be submitted in the format, including the content, prescribed by the department. Within 30 days of receipt of data submitted pursuant to this subdivision, the department shall make a summary of the data available to the public upon request. The department shall verify the accuracy of the data when conducting regional center fiscal audits. Data submitted by regional centers pursuant to this subdivision shall:

(1) Only include data on service coordinator positions as defined in subdivision (d). Regional centers shall identify the number of positions that perform service coordinator duties on less than a full-time basis. Staffing ratios reported pursuant to this subdivision shall reflect the appropriate proportionality of these staff to consumers served.

(2) Be reported separately for service coordinators whose caseload includes any of the following:

(A) Consumers who are three years of age and older and who have not moved from the developmental center to the community since April 14, 1993.

(B) Consumers who have moved from a developmental center to the community since April 14, 1993.

(C) Consumers who are younger than three years of age.

(D) Consumers enrolled in the Home and Community-based Services Waiver program.

(3) Not include positions that are vacant for more than 60 days or new positions established within 60 days of the reporting month that are still vacant.

(4) For purposes of calculating caseload ratios for consumers enrolled in the Home- and Community-based Services Waiver program, vacancies shall not be included in the calculations.

(f) The department shall provide technical assistance and require a plan of correction for any regional center that, for two consecutive reporting periods, fails to maintain service coordinator caseload ratios required by this section or otherwise demonstrates an inability to maintain appropriate staffing patterns pursuant to this section. Plans of correction shall be developed following input from the local area board, local organizations representing consumers, family members, regional center employees, including recognized labor organizations, and service providers, and other interested parties.

(g) Contracts between the department and regional center shall require the regional center to have, or contract for, all of the following areas:

(1) Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.

(2) Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.

(3) Family support expertise to assist the regional center in maximizing the effectiveness of support and services provided to families.

(4) Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supportive living arrangements.

(5) Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.

(6) Quality assurance expertise, to assist the regional center to provide the necessary coordination and cooperation with the area board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.

(7) Each regional center shall employ at least one consumer advocate who is a person with developmental disabilities.

(8) Other staffing arrangements related to the delivery of services that the department determines are necessary to ensure maximum cost-effectiveness and to ensure that the service needs of consumers and families are met.

(h) Any regional center proposing a staffing arrangement that substantially deviates from the requirements of this section shall request a waiver from the department. Prior to granting a waiver, the department shall require a detailed staffing proposal, including, but not limited to, how the proposed staffing arrangement will benefit consumers and families served, and shall demonstrate clear and convincing support for the proposed staffing arrangement from constituencies served and impacted, that include, but are not limited to, consumers, families, providers, advocates, and recognized labor organizations. In addition, the regional center shall submit to the department any written opposition to the proposal from organizations or individuals, including, but not limited to, consumers, families, providers, and advocates, including recognized labor

organizations. The department may grant waivers to regional centers that sufficiently demonstrate that the proposed staffing arrangement is in the best interest of consumers and families served, complies with the requirements of this chapter, and does not violate any contractual requirements. A waiver shall be approved by the department for up to 12 months, at which time a regional center may submit a new request pursuant to this subdivision.

(i) The requirements of subdivisions (c), (f), and (h) shall not apply when a regional center is required to develop an expenditure plan pursuant to Section 4791, and when the expenditure plan addresses the specific impact of the budget reduction on staffing requirements and the expenditure plan is approved by the department.

(j) (1) Any contract between the department and a regional center entered into on and after January 1, 2003, shall require that all employment contracts entered into with regional center staff or contractors be available to the public for review, upon request. For purposes of this subdivision, an employment contract or portion thereof may not be deemed confidential nor unavailable for public review.

(2) Notwithstanding paragraph (1), the social security number of the contracting party may not be disclosed.

(3) The term of the employment contract between the regional center and an employee or contractor shall not exceed the term of the state's contract with the regional center.

SEC. 49. Section 4643 of the Welfare and Institutions Code is amended to read:

4643. (a) If assessment is needed, prior to July 1, 2007, 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, 2007, 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. 50. Section 4648.4 of the Welfare and Institutions Code is amended to read:

4648.4. (a) Notwithstanding any other provision of law or regulation, commencing July 1, 2006, rates for services listed in paragraphs (1), (2), with the exception of travel reimbursement, (3) to (8), inclusive, (10), and (11) of subdivision (b), shall be increased by 3 percent, subject to funds specifically appropriated for this increase in the Budget Act of 2006. The increase shall be applied as a percentage, and the percentage shall be the same for all providers. Any subsequent change shall be governed by subdivision (b).

(b) Notwithstanding any other provision of law or regulation, except for subdivision (a), during the 2006–07 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 July 1, 2006, unless the increase is required by a contract between the regional center and the vendor that is in effect on June 30, 2006, 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:

(1) Supported living services.
(2) Transportation, including travel reimbursement.
(3) Socialization training programs.
(4) Behavior intervention training.
(5) Community integration training programs.
(6) Community activities support services.
(7) Mobile day programs.
(8) Creative art programs.
(9) Supplemental day services program supports.
(10) Adaptive skills trainers.
(11) Independent living specialists.

SEC. 51. Section 4681.3 of the Welfare and Institutions Code is amended to read:

4681.3. (a) Notwithstanding any other provision of this article, for the 1996–97 fiscal year, the rate schedule authorized by the department in operation June 30, 1996, shall be increased based upon the amount appropriated in the Budget Act of 1996 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(b) Notwithstanding any other provision of this article, for the 1997–98 fiscal year, the rate schedule authorized by the department in operation on June 30, 1997, shall be increased based upon the amount appropriated in the Budget Act of 1997 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(c) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on June 30, 1998, shall be increased commencing July 1, 1998, based upon

the amount appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(d) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on December 31, 1998, shall be increased January 1, 1999, based upon the cost-of-living adjustments in the Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a percentage and the percentage shall be the same for all providers.

(e) Notwithstanding any other provision of this article, for the 1999–2000 fiscal year, the rate schedule authorized by the department in operation on June 30, 1999, shall be increased July 1, 1999, based upon the amount appropriated in the Budget Act of 1999 for that purpose. The increase shall be applied as a percentage and the percentage shall be the same for all providers.

(f) In addition, commencing January 1, 2000, any funds available from cost-of-living adjustments in the Supplemental Security Income/State Supplementary Payment (SSI/SSP) for the 1999–2000 fiscal year shall be used to further increase the community care facility rate. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(g) Notwithstanding any other provision of law or regulation, for the 2006–07 fiscal year, the rate schedule in effect on June 30, 2006, shall be increased on July 1, 2006, by 3 percent, subject to funds specifically appropriated for this increase in the Budget Act of 2006. The increase shall be applied as a percentage and the percentage shall be the same for all providers. Any subsequent increase shall be governed by Section 4681.5.

SEC. 52. 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 2006–07 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 July 1, 2006, 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. 53. Section 4690.5 is added to the Welfare and Institutions Code, to read:

4690.5. Notwithstanding any other provision of law or regulation, commencing July 1, 2006, the rate for family member-provided respite services authorized by the department and in operation June 30, 2006, shall be increased by 3 percent, subject to funds specifically appropriated for this increase in the Budget Act of 2006. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

SEC. 54. Section 4691.6 of the Welfare and Institutions Code is amended to read:

4691.6. (a) Notwithstanding any other provision of law or regulation, commencing July 1, 2006, the community-based day program, work activity program, and in-home respite service agency rate schedules authorized by the department and in operation June 30, 2006, shall be increased by 3 percent, subject to funds specifically appropriated for this increase in the Budget Act of 2006. The increase shall be applied as a percentage, and the percentage shall be the same for all providers. Any subsequent increase shall be governed by subdivisions (b), (c), (d), and (e).

(b) Notwithstanding any other provision of law or regulation, during the 2006–07 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 July 1, 2006, if the permanent payment rate would be greater than the temporary payment rate in effect on or after July 1, 2006, unless the regional center demonstrates to the department that the permanent payment rate is necessary to protect the consumers' health or safety.

(c) Notwithstanding any other provision of law or regulation, during the 2006–07 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 July 1, 2006, 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.

(d) Notwithstanding any other provision of law or regulation, during the 2006–07 fiscal year, the department may not approve an anticipated rate adjustment 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 July 1, 2006, unless the regional center demonstrates that the anticipated rate adjustment is necessary to protect the consumers' health or safety.

(e) Notwithstanding any other provision of law or regulation, during the 2006–07 fiscal year, the department may not approve any rate adjustment for a work activity 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 July 1, 2006, 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. 55. Section 4691.8 is added to the Welfare and Institutions Code, to read:

4691.8. (a) Notwithstanding any other provision of law or regulation, and to the extent funds are appropriated in the annual Budget Act for this purpose, the department may provide a rate increase for the purpose of enhancing wages for direct care staff in day programs and in work activity

programs, as defined in subdivision (e) of Section 4851, and in look-alike programs, that meet any of the following criteria:

(1) Provide a majority of their services and supports in integrated community settings.

(2) Are day programs that are converting to integrated community settings.

(3) Are work activity programs that are converting to supported work programs.

(b) The department may approve a temporary rate increase for a program that is converting pursuant to paragraph (2) or (3) of subdivision (a). A program shall not be eligible for a permanent rate increase pursuant to this section unless it meets the criteria established in paragraph (1) of subdivision (a).

(c) A rate increase provided pursuant to paragraph (1) of subdivision (a) to existing programs shall be effective not more than 60 days following the adoption of the Budget Act that appropriates the necessary funding.

(d) Prior to implementation of this section, the department shall consult with stakeholders, including various provider organizations, the regional centers, and all other interested parties.

(e) The department shall provide the Legislature, by April 1, 2007, with a description of how this section has been implemented, along with the following information:

(1) The number of day programs and work activity centers receiving an enhanced rate, by regional center.

(2) The number of program conversions, by regional center.

(3) The percentage of rate increase provided to programs.

(4) The effect of the rate increase on direct care staff wages.

SEC. 56. Section 4694 is added to the Welfare and Institutions Code, to read:

4694. Commencing July 1, 2006, all regional center vendors who are qualified providers under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and are serving individuals enrolled under the Home- and Community-based Services Waiver program for persons with developmental disabilities, shall ensure that billing information provided to regional centers identifies each individual consumer and, for each consumer, the specific dates of service, location of service, service unit, unit costs, and other information necessary to support billing under the home- and community-based services waiver. Regional centers shall also ensure that their contractual and other billing and payment arrangements with providers require the provision of any information necessary to support billing under the Home- and Community-based Services Waiver program. Resources provided to regional centers, pursuant to the Budget Act of 2006 and following budgets, to implement this provision shall be allocated to the regional centers only until implementation of a statewide electronic data system that collects the billing information necessary to support billing under the Home- and Community-based Services Waiver program.

SEC. 57. Section 4781.5 of the Welfare and Institutions Code is amended to read:

4781.5. (a) For the 2006–07 fiscal year only, a regional center may not expend any purchase of service funds for the startup of any new program unless one of the following criteria is met:

(1) The expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances.

(2) The program to be developed promotes and provides integrated supported work options for individuals or groups of no more than three consumers.

(3) The program to be developed promotes and provides integrated social, civic, volunteer, or recreational activities.

(b) Notwithstanding subdivision (a), a regional center may approve grants to current providers to engage in new or expanded employment activities that result in greater integration, conversion from sheltered to supported work environments, self-employment, and increased consumer participation in the federal Ticket to Work program.

(c) Startup contracts for programs funded under this section shall be outcome-based.

(d) The department shall develop criteria by which regional centers shall approve grants, and shall provide prior written authorization for the expenditures under this section.

(e) This section shall not apply to any of the following:

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

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

SEC. 58. Section 4860 of the Welfare and Institutions Code is amended to read:

4860. (a) (1) The hourly rate for supported employment services provided to consumers receiving individualized services shall be thirty-four dollars and twenty-four cents ($34.24).

(2) Job coach hours spent in travel to consumer worksites may be reimbursable for individualized services only when the job coach travels from the vendor's headquarters to the consumer's worksite or from one consumer's worksite to another, and only when the travel is one way.

(b) The hourly rate for group services shall be thirty-four dollars and twenty-four cents ($34.24), regardless of the number of consumers served in the group. Consumers in a group shall be scheduled to start and end work at the same time, unless an exception that takes into consideration the consumer's compensated work schedule is approved in advance by the regional center. The department, in consultation with stakeholders, shall adopt regulations to define the appropriate grounds for granting these exceptions. When the number of consumers in a supported employment placement group drops to fewer than the minimum required in subdivision (r) of Section 4851 the regional center may terminate funding for the group services in that group, unless, within 90 days, the program provider

adds one or more regional center, or Department of Rehabilitation funded supported employment consumers to the group.

(c) Job coaching hours for group services shall be allocated on a prorated basis between a regional center and the Department of Rehabilitation when regional center and Department of Rehabilitation consumers are served in the same group.

(d) When Section 4855 applies, fees shall be authorized for the following:

(1) A four hundred dollar ($400) fee shall be paid to the program provider upon intake of a consumer into a supported employment program. No fee shall be paid if that consumer completed a supported employment intake process with that same supported employment program within the previous 12 months.

(2) An eight hundred dollar ($800) fee shall be paid upon placement of a consumer in an integrated job, except that no fee shall be paid if that consumer is placed with another consumer or consumers assigned to the same job coach during the same hours of employment.

(3) An eight hundred dollar ($800) fee shall be paid after a 90-day retention of a consumer in a job, except that no fee shall be paid if that consumer has been placed with another consumer or consumers, assigned to the same job coach during the same hours of employment.

(e) Notwithstanding paragraph (4) of subdivision (a) of Section 4648 the regional center shall pay the supported employment program rates established by this section.

SEC. 59. Section 5675.2 of the Welfare and Institutions Code is amended to read:

5675.2. (a) There is hereby created in the State Treasury the Licensing and Certification Fund, Mental Health, from which money, upon appropriation by the Legislature in the Budget Act, shall be expended by the State Department of Mental Health to fund administrative and other activities in support of the department's Licensing and Certification Program.

(b) Commencing January 1, 2005, each new and renewal application for a license to operate a mental health rehabilitation center shall be accompanied by an application or renewal fee.

(c) The amount of the fees shall be determined and collected by the State Department of Mental Health, but the total amount of the fees collected shall not exceed the actual costs of licensure and regulation of the centers, including, but not limited to, the costs of processing the application, inspection costs, and other related costs.

(d) Each license or renewal issued pursuant to this chapter shall expire 12 months from the date of issuance. Application for renewal of the license shall be accompanied by the necessary fee and shall be filed with the department at least 30 days prior to the expiration date. Failure to file a timely renewal may result in expiration of the license.

(e) License and renewal fees collected pursuant to this section shall be deposited into the Licensing and Certification Fund, Mental Health.

(f) Fees collected by the department pursuant to this section shall be expended by the department for the purpose of ensuring the health and safety of all individuals providing care and supervision by licensees and to support activities of the Licensing and Certification Program, including, but not limited to, monitoring facilities for compliance with applicable laws and regulations.

(g) The department may make additional charges to the facilities if additional visits are required to ensure that corrective action is taken by the licensee.

SEC. 60. Section 14007.2 is added to the Welfare and Institutions Code, to read:

14007.2. (a) Any individual who is otherwise eligible for Medi-Cal services, but who does not meet the documentation requirements described in subdivision (e) of Section 14011.2, shall be eligible only for the scope of services made available to aliens under subdivision (d) of Section 14007.5, and Sections 14007.65 and 14007.7.

(b) To the extent that federal financial participation is available to fund services described under subdivision (a), the department shall file all necessary state plan amendments to obtain that funding.

SEC. 61. Section 14011.2 of the Welfare and Institutions Code, as added by Section 66 of Chapter 722 of the Statutes of 1992, is amended to read:

14011.2. (a) The department shall require that each applicant for or beneficiary of Medi-Cal, including a child, who is not a recipient of aid under the provisions of Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall provide his or her social security account number, or numbers, if he or she has more than one such number.

(b) The requirement for a social security account number shall be a condition of eligibility only for the applicant who is seeking or the beneficiary who is receiving (1) full-scope medical benefits or (2), pursuant to Section 14007.5, restricted medical benefits (emergency and pregnancy-related services only), and, in either case, who declares, as required in subdivision (d), that he or she is a citizen or national of the United States, and, if he or she is not a citizen or national of the United States, that he or she has satisfactory immigration status.

(c) The requirement for a social security account number shall not be a condition of eligibility for the applicant who is seeking or the beneficiary who is receiving, pursuant to Section 14007.5, restricted medical benefits (emergency and pregnancy-related services only), and who has not made the declaration, as required in subdivision (d), that he or she is not a citizen or national of the United States, and, if he or she is not a citizen or national of the United States, that he or she does not have satisfactory immigration status.

(d) Every applicant or beneficiary or, in the case of a child, by the child’s caretaker relative or legal guardian on his or her behalf shall

declare, under penalty of perjury, that he or she is, or is not any of the following:

(1) A citizen of the United States.

(2) A national of the United States.

(3) An alien who has satisfactory immigration status.

(e) (1) Notwithstanding Section 50301.1 of Title 22 of the California Code of Regulations, an individual who declares to be a citizen or national of the United States in accordance with Section 1903(i)(22) of the federal Social Security Act (42 U.S.C. Sec. 1396b(i)(22)) shall present satisfactory documentary evidence of citizenship or nationality in compliance with Section 1903(x) (42 U.S.C. Sec. 1396b(x) of the federal Social Security Act). Except as otherwise provided in Section 14007.2, no services shall be available under this chapter for an individual who fails to comply with the documentation requirements of this section.

(2) (A) The documentation required pursuant to paragraph (1) shall be provided once by each individual, as follows:

(i) During the initial application process for applicants.

(ii) During the redetermination process for existing beneficiaries.

(B) If the documentation is obtained from a beneficiary, the county shall maintain a copy of the documentation in the case file of the beneficiary, and shall not request this documentation again.

(C) If electronic verification is used, a record of the documentation shall be maintained in the case record and shall not be requested again.

(D) Once the required documentation has been obtained by the county, the beneficiary shall not be required to provide it again, even if he or she is transferring to or applying in a new county.

(3) To the extent that federal financial participation is available, the department shall provide for exceptions or alternatives to the documentation requirements imposed by this subdivision as a means of providing individuals with increased flexibility and ability to provide satisfactory documentary evidence within a reasonable period of time. These exceptions or alternatives may include, but shall not be limited to, using an expanded list of acceptable documents, relying on electronic data matches for birth certificates, relying on a sworn affidavit of citizenship with respect to an individual who can demonstrate good cause for his or her inability or other failure to provide the required documentation, and relying on other information that may be available electronically.

(4) (A) To the extent that federal financial participation is available, the department shall rely on the eligibility determinations for the CalWORKs program or the Aid to Families with Dependent Children-Foster Care program as meeting the requirements of this section.

(B) To the extent that federal financial participation is available, an individual shall be deemed to have met the documentation requirements of this subdivision if the individual has been determined to be eligible for supplemental security income pursuant to Title XVI of the Social Security Act (42 U.S.C. Sec. 1601 et seq.).

(5) The following provisions shall apply to the extent that federal financial participation is available:

(A) If an individual cooperates in the effort to obtain and present the documentation required under this subdivision, the individual shall be given as much time as is allowed by federal law and policy to present that documentation.

(B) During the time period described in subparagraph (A), an applicant shall receive the scope of Medi-Cal benefits for which the applicant is otherwise eligible.

(6) To the extent that federal financial participation is available, the county shall do all of the following to assist an individual in obtaining and presenting the documentation required under this subdivision:

(A) For an applicant who does not present the required documentation at the time of application, the county, during the time period described in subparagraph (A) of paragraph (5), shall assist the applicant in obtaining that documentation.

(B) For a current beneficiary who has not yet documented his or her citizenship, the county shall do the following:

(i) If, at the time of annual redetermination, the beneficiary returns the annual redetermination form and, but for the failure to present the required documentation, continued eligibility could be established, the county shall do the following:

(I) Review county eligibility files and records, and the Medi-Cal Eligibility Data System, to access those documents. This review shall include a review of any CalWORKs or food stamp files that may exist for the beneficiary.

(II) Attempt to reach the beneficiary by telephone to advise the beneficiary as to the need to obtain and present the required documentation.

(III) If the beneficiary fails to respond to the telephone contact or present the required documents, send a second form to the beneficiary that highlights the documentation being requested and informs the beneficiary to contact the county. The form shall be written in a simple, clear, consumer-friendly manner, and shall explain why the documentation is necessary.

(IV) If the beneficiary fails to contact the county, the county shall make another attempt to reach the beneficiary by telephone to advise the beneficiary of the need to obtain and present the required documentation.

(ii) Document in the case file any efforts made to contact and advise the beneficiary as to the need to obtain and present the required documentation.

(C) If a beneficiary fails to present the required documentation after the process required under clause (i), the county shall send a 10-day notice of action to indicate that the beneficiary's benefits are reduced to those made available under Section 14007.2.

(7) (A) Any benefits provided in accordance with subparagraph (B) of paragraph (5) shall terminate if any of the following occurs:

(i) The individual does not obtain and present the required documentation within the time period provided in subparagraph (A) of paragraph (5).

(ii) The documentation is received by the county and the county has made a final determination of eligibility.

(B) The termination of Medi-Cal benefits under this paragraph shall occur without the necessity of further review or determination by the department. This shall not affect an individual's right to a hearing with respect to the denial of the application or termination of eligibility resulting from the annual eligibility redetermination.

(8) 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 subdivision by means of an all county letter or similar instruction without taking regulatory action. Within three years from the date that this subdivision becomes effective, 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.

(9) The department shall notify and consult with advocates, providers, counties, and health plans in implementing, interpreting, or making specific this subdivision.

(10) The department shall file all necessary state plan amendments to implement the requirements of this subdivision. Upon filing any state plan amendment, the department shall provide the appropriate fiscal committees of the Legislature with a copy of the state plan amendment.

(11) If any part of this subdivision is in conflict with or does not comply with federal law, the subdivision shall be implemented only to the extent that federal law permits. Any part that is in conflict with or does not comply with federal law shall be severable from the remaining portions of this subdivision.

SEC. 62. 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) Commencing May 1, 2006, an applicant for certification that meets all of the following:

(A) Is serving persons discharged into community housing from a nursing facility operated by the City and County of San Francisco.

(B) Has submitted, after December 31, 2005, but prior to February 1, 2006, an application for certification that has not been denied.

(C) Meets all criteria for certification imposed under this article and is licensed as an adult day health care center pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code.

(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. 63. Section 14067.3 is added to the Welfare and Institutions Code, to read:

14067.3. (a) (1) The department may maintain an allocation program for the management and funding of county outreach and enrollment plans to enroll and retain eligible children in the Medi-Cal program and the Healthy Families Program.

(2) Notwithstanding any other provision of law, and in a manner that the director shall provide, the department may allocate an amount to fund county outreach and enrollment plans identified in this section.

(b) (1) The sum of three million dollars ($3,000,000) in the 2006–07 fiscal year, and thereafter adjusted proportionately on a pro rata basis contingent upon the annual appropriation, but not less than two million dollars ($2,000,000), shall be set aside, from the annual allocation for purposes of this section, for counties identified in subdivision (d).

(2) Notwithstanding paragraph (1), the total of all county allocations made pursuant to this section shall not exceed the annual appropriation for the implementation of this section.

(c) The director shall make allocations to not more than 20 counties that have the highest number of children who appear to be eligible for the Medi-Cal program or the Healthy Families Program, as determined by the director, but who are not currently enrolled in either program, and the highest number of Medi-Cal program and Healthy Families Program cases for children. This number shall be weighted to emphasize those who appear eligible, but are not currently enrolled in the programs.

(d) With funds set aside under paragraph (1) of subdivision (b), the director shall make allocations to those counties that have an existing infrastructure for outreach, enrollment, retention, and utilization, and that can demonstrate they have well established and documented county coalitions for children's coverage with organizations such as community-based organizations, schools, clinics, labor organizations, and other safety net providers in place for at least 12 months.

(e) (1) To obtain an allocation authorized under this section, a county shall submit an allocation plan, which shall include an outreach and enrollment plan, as outlined in paragraph (2). The director shall establish the procedures and format for submission to the department of all county allocation plans.

(2) The following shall constitute the minimum components required of a county outreach and enrollment plan:

(A) An active collaboration with a wide range of organizations, such as community-based organizations, schools, clinics, labor organizations, and other safety net providers.

(B) A streamlined application assistance process.

(C) Establishment of an oversight, performance management, and review program to ensure that the outreach and enrollment plan submitted by the county is properly implemented and administered.

(D) A description of each of the following:

(i) The amount of the current funding and funding source for application, enrollment, retention, and utilization activities.

(ii) The current application, enrollment, retention, and utilization activities.

(iii) How the allocation funds awarded under this section will be used to supplement and not supplant existing application, enrollment, retention, and utilization activities.

(E) A detailed proposed budget of all expenditures for the relevant fiscal year or years for the county's outreach and enrollment plan activities, expenses, services, materials, and support.

(f) Counties receiving an allocation under this section shall provide reports to the department, as determined by the department, on the progress made in achieving the objectives of the allocation plan.

(g) (1) The funds allocated under this section shall be used only for outreach, enrollment, retention, and utilization. The funds allocated under this section may supplement, but shall not supplant, existing local, state, and foundation funding of county outreach, enrollment, retention, and utilization activities. Notwithstanding Section 10744, the department may recoup or withhold all or part of a county's allocation for failure to comply with the standards set forth in the county's outreach and enrollment plan upon which the allocation was based.

(2) Notwithstanding any other provision in this section, any acquisitions made with funds allocated under this section shall be made in compliance with federal law.

(h) Reimbursements for costs incurred under the allocation plan authorized under this section shall be made in arrears and in a manner as provided by the director. The allocations may be used only to fund activities provided in each of the designated fiscal years and in accordance with the county's approved outreach and enrollment plan and budget for the fiscal year.

(i) As authorized by the director, on a case by case basis, funds allocated pursuant to this section may be used to support automated enrollment of children in the Medi-Cal program or the Healthy Families Program. Funds under this subdivision shall further the goal of increasing the enrollment of uninsured children, as well as increasing the retention of children, in the Medi-Cal program and Healthy Families Program in the same fiscal year for which the funds are allocated.

(j) The department and the Managed Risk Medical Insurance Board shall seek approval of any amendments to the state plan necessary to implement this section for purposes of funding under Titles XIX and XXI of the federal Social Security Act (42 U.S.C. Secs. 1396 et seq. and 1397aa et seq., respectively). This section shall be implemented only when federal approvals have been obtained and only to the extent federal financial participation is available.

(k) The department shall reimburse a county pursuant to this section in lieu of commencing a cooperative agreement or contract with a county for the operation of an outreach program.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department

may implement, interpret, or make specific this section by means of all county letters, provider bulletins, or similar instructions.

(m) For the purposes of this section, "county outreach and enrollment plan" means a county outreach program designed to identify and enroll children who are eligible either for the Healthy Families Program or the Medi-Cal program, but are not currently enrolled in either program, and to facilitate the retention of eligible children currently enrolled in these programs.

SEC. 64. Section 14068 is added to the Welfare and Institutions Code, to read:

14068. In conducting outreach activities for the enrollment of special needs populations into a Medi-Cal managed care program, the department and its contractors, as deemed applicable by the department, shall work with state, local, and regional organizations with the ability to target low-income seniors and individuals with disabilities in the communities where they live. This shall include, but not be limited to, all applicable state departments that serve these individuals, regional centers, seniors' organizations, local health consumer centers, and other consumer-focused organizations that are engaging in providing assistance to this population.

SEC. 65. Section 14105.33 of the Welfare and Institutions Code is amended to read:

14105.33. (a) The department may enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category, and shall maintain a list of those drugs for which contracts have been executed.

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer's best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed-upon price escalators, as defined in that section. The contracts shall provide for an equalization payment amount, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit an invoice to each manufacturer for the equalization payment amount, including supporting utilization data from the department's prescription drug paid claims tapes within 30 days of receipt of the Centers for Medicare and Medicaid Services' file of manufacturer rebate information. In lieu of paying the entire invoiced amount, a manufacturer may contest the invoiced amount pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations by mailing a notice, that shall set forth its grounds for contesting the invoiced amount, to the department within 38 days of the department's mailing of the state invoice and supporting utilization data. For purposes of state accounting practices only, the contested balance shall not be considered an accounts receivable amount until final resolution of the dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations that results in a finding of an underpayment by the manufacturer. Manufacturers may request, and the department shall timely

provide, at cost, Medi-Cal provider level drug utilization data, and other Medi-Cal utilization data necessary to resolve a contested department-invoiced rebate amount.

(2) The department shall provide for an annual audit of utilization data used to calculate the equalization amount to verify the accuracy of that data. The findings of the audit shall be documented in a written audit report to be made available to manufacturers within 90 days of receipt of the report from the auditor. Any manufacturer may receive a copy of the audit report upon written request. Contracts between the department and manufacturers shall provide for any equalization payment adjustments determined necessary pursuant to an audit.

(3) Utilization data used to determine an equalization payment amount shall exclude data from both of the following:

(A) Health maintenance organizations, as defined in Section 300e(a) of Title 42 of the United States Code, including those organizations that contract under Section 1396b(m) of Title 42 of the United States Code.

(B) Capitated plans that include a prescription drug benefit in the capitated rate, and that have negotiated contracts for rebates or discounts with manufacturers.

(4) Utilization data used to determine an equalization payment amount shall include data from all programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers.

(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of therapeutic agents, the department shall ensure that there is representation on the list of contract drugs in all major therapeutic categories. Except as provided in subdivision (a) of Section 14105.35, the department shall not be required to contract with all manufacturers who negotiate for a contract in a particular category. The department shall ensure that there is sufficient representation of single-source and multiple-source drugs, as appropriate, in each major therapeutic category.

(d) The department shall select the therapeutic categories to be included on the list of contract drugs, and the order in which it seeks contracts for those categories. The department may establish different contracting schedules for single-source and multiple-source drugs within a given therapeutic category.

(e) (1) In order to fully implement subdivision (d), the department shall, to the extent necessary, negotiate or renegotiate contracts to ensure there are as many single-source drugs within each therapeutic category or subcategory as the department determines necessary to meet the health needs of the Medi-Cal population. The department may determine in selected therapeutic categories or subcategories that no single-source drugs are necessary because there are currently sufficient multiple-source drugs in the therapeutic category or subcategory on the list of contract drugs to

meet the health needs of the Medi-Cal population. However, in no event shall a beneficiary be denied continued use of a drug which is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(2) In the development of decisions by the department on the required number of single-source drugs in a therapeutic category or subcategory, and the relative therapeutic merits of each drug in a therapeutic category or subcategory, the department shall consult with the Medi-Cal Contract Drug Advisory Committee. The committee members shall communicate their comments and recommendations to the department within 30 business days of a request for consultation, and shall disclose any associations with pharmaceutical manufacturers or any remuneration from pharmaceutical manufacturers.

(f) In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into on a nonbid basis shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) In no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(h) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any drug from the list of contract drugs. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal.

(j) In carrying out the provisions of this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to initially accomplish the treatment authorization request reviews.

(k) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates. The interest shall not apply to any prior period adjustments of unit rebate amounts or department utilization adjustments.

(2) For state rebate payments, manufacturers shall calculate and pay interest on late or unpaid rebates for quarters that begin on or after the effective date of the act that added this subdivision.

(3) Following final resolution of any dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to subdivisions (m) and (n), and any overpayment, together with interest at the rate calculated pursuant to

subdivisions (m) and (n), shall be credited by the department against future rebates due.

(*l*) Interest pursuant to subdivision (k) shall begin accruing 38 calendar days from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(m) Except as specified in subdivision (n), interest rates and calculations pursuant to subdivision (k) for medicaid rebates and state rebates shall be identical and shall be determined by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.

(n) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate and calculations pursuant to subdivision (k) shall be as specified in subdivision (m), however the interest rate shall be increased by 10 percentage points. This subdivision shall apply to payments for amounts invoiced for any quarters that begin on or after the effective date of the act that added this subdivision.

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of mailing of the invoice, and supporting utilization data. If the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, the manufacturer's contract with the department shall be deemed to be in default and the contract may be terminated in accordance with the terms of the contract. For all other manufacturers, if the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, all of the drug products of those manufacturers shall be made available only through prior authorization effective 270 days after the date of mailing of the invoice, including utilization data sent to manufacturers.

(p) If the manufacturer provides payment or evidence of payment to the department at least 40 days prior to the proposed date the drug is to be made available only through prior authorization pursuant to subdivision (o), the department shall terminate its actions to place the manufacturers' drug products on prior authorization.

(q) The department shall direct the state's fiscal intermediary to remove prior authorization requirements imposed pursuant to subdivision (o) and notify providers within 60 days after payment by the manufacturer of the rebate, including interest. If a contract was in place at the time the manufacturers' drugs were placed on prior authorization, removal of prior authorization requirements shall be contingent upon good faith negotiations and a signed contract with the department.

(r) A beneficiary may obtain drugs placed on prior authorization pursuant to subdivision (o) if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the drug when its manufacturer is placed on prior authorization

status. Additionally, the department shall have received a claim for the drug with a date of service that is within 100 days prior to the date the manufacturer was placed on prior authorization.

(s) A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the drug in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same drug.

(t) Drugs covered pursuant to Sections 14105.43 and 14133.2 shall not be subject to prior authorization pursuant to subdivision (o), and any other drug may be exempted from prior authorization by the department if the director determines that an essential need exists for that drug, and there are no other drugs currently available without prior authorization that meet that need.

(u) It is the intent of the Legislature in enacting subdivisions (k) to (t), inclusive, that the department and manufacturers shall cooperate and make every effort to resolve rebate payment disputes within 90 days of notification by the manufacturer to the department of a dispute in the calculation of rebate payments.

SEC. 66. 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, (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, (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, (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, (3) the actual acquisition cost plus a markup to be established by the department, (4) the manufacturer's suggested retail purchase price on June 1, 2006, and documented by a printed catalog or a hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 20 percent, or not to exceed 15 percent for wheelchairs and wheelchair accessories if the provider employs or contracts with a qualified rehabilitation professional, as defined in paragraph (3) of subdivision (c) of Section 14105.485, 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) Commencing January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes, and shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (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 a 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.

(g) Within six months of the effective date of the act that added this subdivision, the department shall review utilization of services and equipment resulting from the changes to this section made by that act, and shall assess whether the changes are contributing to inappropriate use of those services or equipment. If the department's review finds an increase in inappropriate use of those services or equipment, the Department of Finance shall notify the Joint Legislative Budget Committee of the State Department of Health Services' findings and recommended changes to ensure program integrity.

(h) 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.

(i) 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.

(j) 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.

(k) 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. 67. Section 14105.49 of the Welfare and Institutions Code is amended to read:

14105.49. (a) (1) The department shall establish a list of Healthcare Common Procedure Coding System (HCPCS) codes billable to the Medi-Cal program and reimbursement rates, subject to Section 51319 of Title 22 of the California Code of Regulations, hearing aids, and the list shall be published in the Medi-Cal Provider Manual.

(2) The department may implement this section by provider manual or bulletin. Notwithstanding the provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code), actions of the department under this section shall not be subject to the rulemaking provisions of the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

(b) The maximum reimbursement rate for hearing aids shall not exceed the lesser of the following:

(1) The maximum allowable amount established by the department.

(2) The one-unit wholesale cost, plus a markup determined by the department.

(3) The billed amount.

(4) The rate established by the department's contracting program.

(c) The maximum reimbursement rate for hearing aid supplies and accessories shall not exceed the lesser of the following:

(1) The retail price.

(2) The wholesale cost, plus a markup determined by the department.

(3) The billed amount.

(4) The rate established by the department's contracting program.

(d) The maximum reimbursement rate for molds or inserts shall not exceed the lesser of the following:

(1) The maximum amount allowable established by the department.

(2) The billed amount.

(3) The rate established by the department's contracting program.

(e) The maximum reimbursement for repairs, subsequent to the guarantee period, shall not exceed the lesser of the following:

(1) The invoice cost plus a markup determined by the department.

(2) The billed amount.

(3) The rate established by the department's contracting program.

SEC. 68. Section 14133.07 is added to the Welfare and Institutions Code, to read:

14133.07. (a) Prior authorization for podiatric services provided on an outpatient or inpatient basis shall not be required when all of the following conditions are met:

(1) The services are provided by a doctor of podiatric medicine acting within the scope of his or her practice.

(2) The services are related to trauma, infection management, pain control, wound management, diabetic foot care, or limb salvage.

(3) The services are medically necessary.

(4) An urgent or emergency need for services exists at the time the service is provided.

(5) The patient was referred to the doctor of podiatric medicine by a physician.

(6) Prior authorization is not required for a physician providing the same service.

(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.

(c) This section shall become operative October 1, 2006.

SEC. 69. 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 Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature's intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

(h) 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.

(i) 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.

(j) 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.

(k) 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. 70. Section 14572 of the Welfare and Institutions Code is amended to read:

14572. (a) No Medi-Cal reimbursement shall be made for a service rendered by an adult day health care provider that does not have a license as an adult day health care center or that does not have currently effective Medi-Cal certification pursuant to this chapter.

(b) Notwithstanding subdivision (a), Medi-Cal certification shall be granted as of the date of licensure with respect to, and reimbursement shall be made for, a service rendered on or after that date if the provider meets all of the following requirements:

(1) Is exempt from the moratorium imposed on the certification and enrollment of new adult day health care centers pursuant to paragraph (5) of subdivision (b) of Section 14043.46.

(2) Meets all certification requirements for adult day health care centers, and is enrolled as a Medi-Cal provider.

(3) Provides services in compliance with the requirements of this chapter as of the date the center began providing services to beneficiaries.

SEC. 71. Section 14592 of the Welfare and Institutions Code is amended to read:

14592. (a) The director may contract with up to ten demonstration projects to develop risk-based long-term care pilot programs modeled upon On Lok Senior Health Services in San Francisco. The department shall seek necessary federal waivers for each demonstration site pursuant to Section 1115 of the Social Security Act (42 U.S.C.A. Sec. 1315). The director shall not enter into contracts with any demonstration program unless necessary federal waivers are obtained.

(b) The demonstration sites shall be public or private nonprofit organizations providing or having the capacity to provide, as determined by the director, comprehensive health care services on a risk-based capitated basis to frail elderly persons certifiable for institutional care. Implementation of this section shall be in accordance with Section 4118(g)(1)(2) of the federal Omnibus Budget Reconciliation Act of 1987.

(c) The department shall establish capitation rates paid to each PACE organization at no less than 90 percent of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000). This subdivision shall be implemented only to the extent that federal financial participation is available.

SEC. 72. Section 16809 of the Welfare and Institutions Code, as amended by Section 30 of Chapter 80 of the Statutes of 2005, 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, 2005–06, and 2006–07 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, 2005–06, and 2006–07 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, 2005–06, and 2006–07 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, 2005–06, and 2006–07 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
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. 73. Section 16809 of the Welfare and Institutions Code, as amended by Section 31 of Chapter 80 of the Statutes of 2005, 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, 2005–06, and 2006–07 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. 74. In response to a signed consent decree between the United States Department of Justice, Civil Rights Division, and the state pursuant to the Civil Rights of Institutionalized Persons Act (42 U.S.C. Sec. 1997 and following), the State Department of Mental Health shall, commencing in September 2006, and every three months thereafter until the state is in compliance with the consent decree, provide to the appropriate fiscal and policy committees of the Legislature all of the following:

(a) Copies of all monitoring reports produced within the previous six months by the court monitor jointly appointed by the state and the United States Department of Justice. All reports regarding Metropolitan State Hospital shall be included within these monitoring reports.

(b) Copies of other correspondence between the United States Department of Justice, the court monitor, and the State Department of Mental Health regarding compliance with the consent decree.

SEC. 75. The adoption and one readoption of regulations to implement the amendment of Sections 12693.70, 12696.05, and 12699 of the Insurance Code, and the addition of Section 12695.03 to the Insurance Code, by this act, and to implement enhancements to application assistance payments pursuant to Section 12693.32 of the Insurance Code, shall be deemed to be an emergency and necessary for the immediate preservation of 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 requirements that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. 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 regulation and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

SEC. 76. The Managed Risk Medical Insurance Board shall provide the chairs of the appropriate fiscal and policy committees of the Legislature with copies of each of the individual phases of the evaluation being conducted regarding the Healthy Families Program and the provision of mental health and substance abuse treatment services. These copies shall be provided on a flow basis as appropriate when completed by the contractor.

SEC. 77. (a) The Legislature hereby refers an audit request to the Bureau of State Audits to conduct an audit during the 2007–08 fiscal year of the clinical laboratory oversight programs of the State Department of Health Services to assess the department's practices and procedures for enforcing state laws and regulations regarding the licensing, certification, and registration of clinical laboratories. This audit request shall be considered by the Bureau of State Audits within its overall audit requests.

(b) Any audit conducted pursuant to subdivision (a) shall include, but not be limited to, the following:

(1) A review of the extent and effectiveness of the department's practices and procedures regarding each of the following:

(A) Detecting and determining when clinical laboratories are not in compliance with applicable state laws and regulations.

(B) Investigating cases of possible noncompliance, including, in particular, the investigation of consumer complaints filed with the department against clinical laboratories.

(C) Imposing appropriate sanctions on clinical laboratories that are found not to have complied with state laws and regulations. The audit shall

review, in particular, the frequency and extent of the department's use of its existing authority to assess and collect civil fines, refer violators for criminal prosecution, and bar participation from state and federally funded health programs, and its use of any other means available to enforce state law and regulations regarding clinical laboratories.

(2) Recommendations, if any, for improving state oversight of clinical laboratories.

(c) The results of any audit conducted pursuant to subdivision (a) shall be reported to the chair of the Joint Legislative Budget Committee, and the chairs of the fiscal committees, health policy committees, and the business and professions committees of both houses of the Legislature.

SEC. 78. (a) Of the funds appropriated in Item 4260-111-0001 of Section 2.00 of the Budget Act of 2006 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 2006–07 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) 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.

SEC. 79. The State Department of Mental Health shall revise its method for auditing entities that provide specialty mental health services under the Early and Periodic Screening, Diagnosis, and Treatment Program, and its method for extrapolating data obtained from those audits, pursuant to this section. Commencing July 1, 2006, and continuing thereafter, the following provisions shall apply:

(a) The department shall select statistically valid stratified samples by service function for each entity to be audited.

(b) The department shall not extrapolate the results of any audit to the full audited service function unless the error rate determined by the audit is 5 percent or greater. If the error rate is less than 5 percent, the department shall disallow only the specific claims found to be in error.

(c) The department, in consultation with stakeholders, shall select an independent statistician to review the sampling methodology and extrapolation methodology used by the department. No later than October 1, 2006, the statistician shall prepare a public report on the statistical validity of those methodologies. If the statistician determines either methodology to be invalid, the department shall adopt a new methodology, which shall be used by the department only after its validity is verified by the statistician.

SEC. 80. (a) Commencing on the date that the Budget Act of 2006 is enacted, funds provided to county mental health departments from Item 6110-161-0890 and Item 4440-104-0001 of the Budget Act of 2006 for services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code shall be timely. Those funds shall be used exclusively to provide state-mandated services pursuant to that chapter, and counties shall identify those funds as provided for this purpose in any future claim for state-mandated reimbursement for services provided pursuant to that chapter.

(1) The State Department of Education shall be responsible for the timely distribution of funds appropriated in Item 6110-161-0890 to county offices of education. These funds shall be distributed consistent with an allocation plan formulated by the State Department of Mental Health in consultation with representatives of county mental health departments. The timing of distributions shall meet the following requirements:

(A) A minimum of 50 percent of the appropriated funds shall be provided to county mental health departments through the county offices of education by January 1 of each year.

(B) A minimum of 75 percent of the appropriated funds shall be provided to county mental health departments through the county offices of education by March 1 of each year.

(2) The funds appropriated in Item 4440-104-0001 shall be distributed consistent with an allocation plan formulated by the State Department of Mental Health in consultation with representatives of county mental health departments.

(A) The State Department of Mental Health shall make monthly payments of one-twelfth of 95 percent of the funds appropriated in Item

4440-104-0001 of the Budget Act of 2006 to county mental health departments. The remaining 5 percent shall be allocated upon completion of the settle-up pursuant to paragraph (3).

(B) Commencing in the 2007–08 fiscal year, the State Department of Mental Health shall make monthly payments of the funds appropriated in Item 4440-104-0001 of the annual Budget Act to county mental health departments with adopted memoranda of understanding as required in subdivision (b). The remaining 5 percent shall be allocated upon completion of the settle-up pursuant to paragraph (3).

(3) The State Department of Mental Health shall settle payments to actual allowable costs up to the amount available in Item 4440-104-0001 of the annual Budget Act.

(4) Any additional allowable costs incurred by a county mental health department for services required pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code shall be reimbursed through the state mandate claims process.

(b) (1) Commencing in the 2007–08 fiscal year, as a condition of receiving funds appropriated in Item 4440-104-0001 of the annual Budget Act for mental health services for students with individualized education plans pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, a county mental health department and the appropriate county office of education, or a single entity designated by the county office of education, shall enter into a memorandum of understanding.

(2) The State Department of Mental Health shall develop a template of the memorandum of understanding by October 1, 2006, for use by county mental health departments and county offices of education or their designees. This template shall be developed in collaboration with the State Department of Education and in consultation with county mental health departments and county offices of education. The template for the memorandum of understanding shall contain at a minimum the following elements:

(A) The requirements of Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code in the areas of referrals, data collection, and reporting, including, but not limited to, the recommendations made pursuant to Paragraph (3) of subdivision (b) of Section 56139 of the Education Code and paragraph (1) of subdivision (b) of Section 7576.2 of the Government Code.

(B) Data required to be reported by county mental health departments to county offices of education to meet federal reporting requirements under the federal Individuals With Disabilities Education Act.

(C) A description of the array of services to be delivered consistent with assessments and individualized education plans.

(3) The State Department of Mental Health shall submit the template to the Legislature by October 2, 2006. If the template is not completed by October 1, 2006, the State Department of Mental Health and the State Department of Education shall each report to the Legislature on the status

of the template and the reasons for not meeting the October 1, 2006, deadline.

(c) The memoranda of understanding shall be adopted by county mental health departments and county offices of education or their designees no later than May 1, 2007.

(d) The memoranda of understanding shall be submitted to the State Department of Mental Health by county mental health departments and to the State Department of Education by county offices of education or their designees within 15 days after adoption.

(e) (1) The State Department of Mental Health and the State Department of Education shall, by May 1, 2007, collaboratively develop claiming instructions for the appropriations in Items 6110-161-0890 and 4440-104-0001 for county mental health departments. The claiming instructions shall be for use in the 2007–08 fiscal year, and subsequent fiscal years. The State Department of Mental Health shall have primary responsibility for developing instructions for the General Fund, and the State Department of Education shall have primary responsibility for developing instructions for funds provided pursuant to the federal Individuals With Disabilities Education Act. The State Department of Mental Health and the State Department of Education shall consult with county mental health departments and county offices of education in the development of those instructions.

(2) The principles to be used in developing the claiming instructions shall be to maximize the appropriate use of federal funds and to use federal funds first.

(3) County mental health departments shall submit claims to county offices of education on a timely basis.

(f) (1) Monitoring of county offices of education and their designees, and county mental health departments, shall be consistent with subdivision (a) of Section 56139 of the Education Code, and subdivision (a) of Section 7576.2 of the Government Code.

(2) The State Department of Mental Health and the State Department of Education shall monitor for timely memoranda of understanding.

(3) The State Department of Mental Health may monitor treatment appropriateness to achieve educational goals as outlined in the individualized education plans.

(4) The State Department of Mental Health may audit costs of claims from county mental health programs for services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code. The department may also monitor the cost of claims to determine whether they are based on actual costs for cost-efficient services with rates comparable to similar services funded by other state programs.

(5) The State Department of Education may monitor compliance with individualized education plans and the timeliness of payments from county offices of education to county mental health departments.

SEC. 81. (a) The State Department of Health Services shall provide to the fiscal committees of the Legislature, by no later than March 15, 2007, all of the following information regarding the reimbursement rates paid under the Medi-Cal program:

(1) Where applicable, a percent comparison regarding the reimbursement rates paid under Medi-Cal as compared to the reimbursement rates paid under the federal Medicare Program, excluding rates applicable to dental services, pharmacy, federally-qualified health centers, rural health clinics, and health facilities.

(2) Where applicable, an estimate of the cost for increasing all Medi-Cal reimbursement rates that are comparable to the federal Medicare Program rates, up to a minimum of 50 percent of the rate paid under the federal Medicare Program. The estimate shall take into account increases necessary to keep managed care rates comparable.

(3) For those procedures reimbursed only under the Medi-Cal program, excluding dental services, a prioritized listing of services and procedure codes, as determined by the department, that may merit adjustment based on a review by the department or a contractor. The estimates shall take into account increases necessary to keep managed care rates comparable.

(b) The department may utilize up to three hundred thousand dollars ($300,000) of funds appropriated in Item 4260-101-0001 and three hundred thousand dollars ($300,000) of funds appropriated in Item 4260-101-0890 of the Budget Act of 2006 for the purposes specified in subdivision (a), and may amend existing contracts to expedite any necessary data collection or data analysis.

SEC. 82. (a) The Legislature, in acknowledgment that planning for a disaster is critical to protect the citizens of the State of California, authorizes the California Health and Human Services Agency to implement a plan to improve the state’s ability to respond to a public health emergency. Given the magnitude and importance of this effort, the Legislature requires frequent updates. Consequently, the California Health and Human Services Agency, in consultation with the Office of Emergency Services, shall report, on a quarterly basis commencing October 1, 2006, to the appropriate fiscal and policy committees of the Legislature, on the state’s progress. The report shall provide an update on the acquisition of disaster preparedness equipment and supplies, including ventilators, masks, mobile field hospitals, alternate care sites, and antivirals. The report shall also describe the effect these efforts have had on the state’s ability to respond in the event of a public health disaster.

(b) By no later than November 15, 2006, the California Health and Human Services Agency shall provide to the appropriate fiscal and policy committees of the Legislature the state’s plan for the new health care delivery response system in the event of a disaster.

SEC. 83. 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. 84. 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 2006 at the earliest possible time, it is necessary that this act take effect immediately.

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